contact

SPECIAL SERIES NUMBER 2
JUNE 1979

Christian Medical Commission World Council of Churches 150, route de Ferney 1211 Geneva 20 Switzerland

IN SEARCH OF WHOLENESS...

...when he saw him, he had compassion

HEALING AND CARING

Medical Commission, a sub-unit of the World Council of Churches.
anguage versions: English, French, Spanish and Portuguese. Present
esented in CONTACT deal with varied aspects of the Christian
report topical, innovative and courageous approaches to the

f: Stuart Kingma, Associate Director and Editor, Miriam Reidy,
ative Assistant. The rest of CMC staff also participate actively in
of materials: Nita Barrow, Director, Eric Ram, Associate Director
mec, Secretary for Studies, Trudy Schaefer, Secretary for
Demaurex, Secretary, is responsible for the CONTACT mailing list.
Chêne-Bougeries/Geneva, Switzerland.

yment, which is made possible by the contributions of interested
make a small donation in support of printing and mailing costs are

lete list of these is published regularly and appears in the first issue

priate acknowledgement is made to: "CONTACT, the bi-monthly
World Council of Churches, Geneva."

IN SEARCH OF WHOLENESS...

HEALING AND CARING

INDEX

ABOUT THE AUTHORS

APPIAH-KUBI, Kofi	Social Science Faculty of the University of Science and Technology, Kumasi, Ghana; formerly Executive Secretary of the Department of Theology, All Africa Conference of Churches.
BECKEN, Hans-Jürgen	Secretary for Germany, Association of Churches and Missions in South-Western Germany, Stuttgart; formerly Rector of the Lutheran Theological College, Mapumulo, Natal.
BRYANT, John H.	Director, Office of International Health, Department of Health, Education and Welfare, Government of the USA; formerly Director of the School of Public Health, Columbia University, New York, and former staff member of the Rockefeller Foundation. Member of the CMC and its Chairman for a number of years.
JENKINS, David	Professor of Theology, Department of Theology and Religious Studies, Leeds University; formerly Director of the William Temple Foundation, Manchester Business School. CMC member for a number of years.
LAMBOURNE, Robert A.	(†) Formerly Psychiatrist and Lecturer in Pastoral Counselling at the University of Birmingham.
MC GREGOR, Donald	Christian Mission to Many Lands (Church of the Brethren), Papua New Guinea.
TOURNIER, Paul	General Practitioner in Geneva for nearly 50 years and author of many books; now in active retirement.
WILSON, Michael	Lecturer in Pastoral Studies, University of Birmingham; formerly medical missionary in Ghana and then Lecturer at St Martin's in the Field Church, London.

PREFACE

The tradition of theological reflection has always been a part of the concerns and activities of the Christian Medical Commission (CMC). The tradition actually began some years before the CMC came into being as an agency of the World Council of Churches (WCC) in 1968. The formal roots of this study process date back to the 1964 Consultation on "The Healing Ministry in the Mission of the Church", held at Tübingen in the Federal Republic of Germany. This consultation has since become known as Tübingen I, 1964. The participants, drawn from the constituencies of the Lutheran World Federation (LWF) as well as those of the WCC, determined to carry out a broad range of investigative activities to follow up the findings of the consultation (see the Statement of Tübingen I, Section IX), and set the stage for a second consultation on Salvation and Healing.

The second consultation was convened in Tübingen in 1967 to examine "Health: Medical-Theological Perspectives" (now referred to as Tübingen II, 1967). In addition to sustaining the creative vigour of the study and reflection programme on the healing ministry, this consultation contributed to defining the need for the creation of an ecumenical agency to assist the churches in their search for relevant styles of health care involvement.

Since its inception in 1968, the CMC has maintained this dual role on behalf of the churches. On the very practical side, it has seen its role as primarily one of helping churches and their medical programmes to rethink the whole question of the Christian responsibility for the development of health care to the total population of the area they serve. From the outset, this has meant a stress on community-based programmes and an involvement in the current promotion of Primary Health Care. In order to function effectively as a resource for the churches and the wider community of health workers around the world, a great deal of energy has been devoted to the matter of information exchange. The main vehicle for this has been the bi-monthly bulletin of the CMC, CONTACT, begun in 1970 and now serving a readership of over 14,000.

The CMC has also attempted to maintain the reflection and study side of its life. Since 1977, the theme of this study has been "The Christian Understanding of Health, Healing and Wholeness." The strength of this enquiry has been the growing network of correspondents and friends in all parts of the world who are actively involved with congregations and caring groups in exploring these concepts. Over the years, a number of the more important documents which highlight the progression of thought have appeared in CONTACT in order to stimulate further exploration of this subject in the churches.

Beginning in 1979, a number of consultations will be held under the sponsorship of the CMC to focus on three topic areas in this study process: the churches' understanding of healing and wholeness; traditional healing practices; and human values in bioethical issues. Since a number of the more important papers in the CMC's study series are now out of print, it was decided to publish this collection of papers and make them available to those who will take part in the ongoing study/enquiry, and to any others who may be interested.

The CMC would like once again to extend an invitation to all those who are concerned with the churches' ministry of healing. We would like to have you share with us your thoughts on these topics, to hear what you are doing with your congregation or group, and to learn what insights have emerged from your work. The study will only be meaningful if it reflects the concerns and thinking of people from congregations, health institutions, church offices and study groups from around the world who would thus contribute to the search for a broader understanding of health, healing and wholeness.

1

CHAPTER I:

THE BEGINNINGS — TÜBINGEN I, 1964

Healing has always played a central role in the work of the Christian church. This has been especially important since the turn of the century and the rapid growth of the work of medical missions. However, it was not until some twenty years ago that some of the more difficult questions began to arise about the role of medical work in the life of the church.

In 1962, the Commission on World Mission of the Lutheran World Federation and the Division of World Mission and Evangelism of the World Council of Churches decided to plan a meeting to look at some of the essential issues facing medical missions. The meeting took place in May of 1964 at the German Institute for Medical Missions (Deutsches Institut für Ärztliche Mission) in Tübingen, Federal Republic of Germany. In the course of the week that the participants spent together, a number of new insights and convictions emerged which have addressed the concerns of many who were wrestling with the problems of medical missions, and of others involved with the healing ministry in one form or another.

Several of the main background papers for this consultation were published in the World Council Studies Series no. 3 (1965) under the title, **The Healing Church:**

1. Lesslie Newbigin: The Healing Ministry in the Mission of the Church
2. Erling Kayser: Medicine and Modern Philosophy: an Introduction
3. Martin Scheel: Some Comments on Pre-scientific Forms of Healing
4. John Wilkinson: Christian Healing and the Congregation

(See inside front cover information on how this document can be obtained.)

The conclusions of this consultation were summarized in the form of a "statement" which has now become known as the Statement of Tübingen I. Because this was such an important beginning for both the dialogue of the last fifteen years on the Healing Ministry of the Church, and for those impulses which led ultimately to the formation of the Christian Medical Commission in 1968, we reproduce the text of that Statement here.

STATEMENT OF TÜBINGEN I, 1964

I PREAMBLE

Within the context of papers presented and discussions which took place, the Consultation adopted the findings which follow. Conscious of a commission from the Lord of the Church, the members of the Consultation sought for a response to this call which might, God willing, prove worthy of its source. We believe that the statement on the Christian Concept of the Healing Ministry and the implications which follow are revolutionary to much of the church's present involvement in medical work.

Mission boards and societies and national churches are still promoting medical work in terms of meeting physical need or providing avenues for the preaching of the Word, all within a varied understanding of Christian compassion and concern. Yet the valid criticism by younger churches that such institutions are a "burden" to them, and the lack of intimate involvement in medical institutions in the West points up the absence of a sufficient distinction between much Christian medical work and the service of secular agencies. It is our earnest hope that these findings may lead to the criteria by which existing and projected Christian medical work can be evaluated.

The members of this Consultation are well aware of the fate of most reports. In view of their unanimous adoption of these findings and because of their

concern for a new look at the Christian healing ministry, they would urge a deep and continuing study of these findings by the Division of World Mission and Evangelism (DWME) of the World Council of Churches (WCC) and the Commission on World Mission of the Lutheran World Federation (LWF), which bodies called them together. In addition, they would request that all churches, young or old, church councils, mission boards and societies as well as theological colleges and seminaries would singly or in partnership examine and test them and, where they are found valid, implement them, whether in pilot projects or as ground work for the adoption of new policies.

II THE CHRISTIAN CONCEPT OF THE HEALING MINISTRY

1. The Christian church has a specific task in the field of healing

This is to say more than simply that the church has a duty to support all that contributes to the welfare of man.

It is to say that there are insights concerning the nature of health which are available only within the context of the Christian faith. The church cannot surrender its responsibility in the field of healing to other agencies. This, however, leaves entirely open the question whether in a given situation, the church best discharges its duty in the field of healing through the maintenance of hospitals, clinics and similar institutions with their medical teams, or through the work of Christians in secular institutions, or through a combination of both.

2. The specific character of the Christian understanding of health and of healing arises from its place in the whole Christian belief about God's plan of salvation for mankind.

The Christian understanding of healing begins from its place in the ministry of Jesus. There it was a sign of the breaking into human life of the powers of the Kingdom of God, and of the dethroning of the powers of evil. The health which was its fruit was not something static, a restored equilibrium; it was an involvement with Jesus in the victorious encounter of the Kingdom of God with the powers of evil.

A concept of health which is merely that of a restored balance, a static "wholeness", has no answer to the problem of human guilt or death, nor to the anxiety and the threat of meaninglessness which are the projection upon human life of the shadow of death. Health, in the Christian understanding, is a continuous and victorious encounter with the powers that deny the existence and goodness of God. It is a participation in an invasion of the realm of evil, in which final victory lies beyond death, but the power of that victory is known now in the gift of the life-giving Spirit. It is a kind of life which has overcome death and the anxiety which is the shadow of death. Whether in the desperate squalor of overpopulated and underdeveloped areas, or in the spiritual wasteland of affluent societies, it is a sign of God's victory and a summons to his service.

The church's ministry of healing is thus an integral part of its witness to the Gospel. In the exercise of this healing function the church must never be indifferent to the patient's spiritual condition, his religious faith or unbelief.

3. The Christian ministry of healing belongs primarily to the congregation* as a whole, and only in that context to those who are specially trained.

If healing is understood as above, it will be clear that the entire congregation has a part to play in it. By its prayer, by the love with which it surrounds each person, by the practical acts which express its concern for every man, and by the opportunities which it offers for participation in Christ's mission, the congregation is the primary agent of healing. At the heart of this healing activity lies the ministry of the Word, Sacraments and prayer. The specialized work of those who have been trained in the techniques of modern medicine have their proper place and will be fruitful in the context of this whole congregational life. We have to recognize that a rift has developed between the work of those with specialized medical training and the life of the congregation, so that the congregation often does not see how it can take a real responsibility for the work of a healing institution. One of the most urgent needs of today is that Christian congregations, in collaboration with Christian medical workers, should again recognize and exercise the healing ministry which belongs properly to them.

4. The Christian ministry of healing as exercised by the church is subject to Him who is the Lord and Head of the church, and to the continuing guidance of the Holy Spirit.

It follows that the form and expression of the church's ministry of healing must be kept under constant review, particularly in relation to the mission and ministry of the church in each generation. For this purpose the church must seek and follow the continuing guidance of the Holy Spirit in the exercise of its healing ministry.

---

* By "congregation" in this Report is meant the corporate fellowship of the People of God wherever it manifests itself.

III THE ROLE OF THE CONGREGATION IN THE MINISTRY OF HEALING

1. In Scripture both sickness and healing are distinctly corporate experiences (Cf. e.g. I Corinth. 12: 12-31; James 5: 13-16).

The ministry of healing in its fullest sense was a natural concern of the early church. To the Christian of today the ministry of healing is very often thought of in terms of *professional* service alone — perhaps even in a distant country — having very little connection with the life of the congregation.

There is an urgent need for revival of the biblical idea of the ministry of healing as service centred in the congregation. Exploration is needed of ways whereby this service can be related to existing forms of medical practice.

2. All healing is of God

This is so whether or not it seems to occur through what we call natural laws — some of which we know, whether or not it appears to have been brought about by what we call medical means, or whether or not it has been accomplished by means of spiritual healing.

This should be accepted even to the extent that all the achievements of modern medicine ultimately are to be understood as signs of the healing power of God.

For this very reason we accept modern medicine as a gift from God and use with the same gratitude both the spiritual and the scientific means of healing.

3. Within this understanding it follows that the congregation has a central and responsible role in the healing ministry.

There are many practical ways of serving the sick. True fellowship with the patient in his particular situation will make it clear how to relieve much of the anxiety and the many practical problems associated with illness.

In this connection it should be mentioned that, among others, the aged, the handicapped, the mentally ill and those suffering from addictions need special care.

In addition to practical acts of love and service, the congregation is entrusted with sanctified means of healing by the ministry of the Word, the Sacraments and prayer with and for the sick.

The manner in which these means are administered will vary according to the tradition of the individual church and the condition of the patient. They may include healing services, laying on of hands, anointing, etc. We do, however, disapprove of those healing services which disregard proper medical means, take place without preparation and follow-up and have a tendency to exploit the patient.

Special problems arise when the patient needs institutional care. These involve additional anxieties and often the need for special pastoral care. It is the obligation of the congregation to see that this is made available.

4. The congregation has a very special responsibility for those of its members who are engaged in medical institutional work.

This is true of those in Christian institutions, but Christian doctors, nurses, ancillary staff members and trainees working in secular institutions too often have been isolated in the secular atmosphere, and, as they are called upon to carry out the ministry of healing, they should as far as possible be drawn into the full fellowship of the local church and particularly given the pastoral care they need.

5. The congregation should encourage its members to enter the healing professions.

The congregation, which in common with its healing Lord is entrusted with the gift of the healing ministry to the world, is called to help its members, especially the young, to obey this calling and to prepare themselves for service in the different forms of the ministry of healing.

IV THE HEALING MINISTRY IN THEOLOGICAL TRAINING

1. A Christian understanding of healing is already implicit in theology.

Much teaching on the ministry of healing is already implicit in courses on systematic and biblical theology given during theological training.

2. In spite of this, no explicit teaching on the Christian understanding of healing is given in most of our theological colleges and seminaries.

Even in the exposition of such basic Christian doctrines as the Atonement, no attempt is made in current theological teaching to bring out their implications for the Christian ministry of healing.

3. It is imperative that teaching should be given on this subject in all our theological colleges and seminaries.

Such teaching is not given because theological teachers have not been given the necessary guidance and stimulus required in this area. The church's ministry of healing should be included in the

syllabus of any courses arranged for theological teachers under the auspices of the Theological Education Fund and similar agencies.

4. The department of theological education in which the practical significance of the ministry of healing can most effectively be made explicit is that of pastoral theology.

Theological teaching staff should be encouraged along two lines. Firstly to develop courses in which the church's ministry of healing is studied and practised. These courses should be based in the seminary or college, but should include periodic hospital and field visitation. Secondly to initiate courses in clinical pastoral training where these do not exist, and to include these in normal theological training. The purpose of clinical training is to train chaplains to work as members of a healing team, but also to train parish pastors to increase and deepen the care and cure of souls as part of the healing ministry of the congregation.

5. The laity also need training in the ministry of healing, and this must be kept in mind in theological training.

Theologians have tended to see their task completed in training a specialized ministry, but the laity also need training. The theological college and seminary should, therefore, train their students to be trainers of the laity who, as members of the congregation, should carry on the essential ministry of healing.

V THE TRAINING OF MEDICAL AND PARA-MEDICAL WORKERS AS A TASK OF THE CHURCH

1. The Consultation emphasises that continuing efforts to improve the professional quality of medical work and the teaching of co-workers need to be recognized as an integral and essential part of any form of medical-evangelistic service. The scope of such teaching should include the patient, his family, all members of the medical team, the local community and its practising physicians as well as other health workers.

2. The Consultation recognizes the churches' responsibility in medical education and urges that WCC and LWF appoint a competent person to conduct an exhaustive study which would evaluate the relative merits of conducting church-sponsored and church-managed medical schools, or of providing instead material and spiritual care for Christian students in secular institutions. This study should be worldwide in scope.

3. It is urged that immediate consideration be given to the extension of intern and residency training facilities in existing church-related hospitals.

4. In view of the intimate relationship of nurse and patient, the Consultation believes that nursing education should be carried on at every level. It recommends, however, that new training programmes be initiated on a regional basis, that they be in conformity with relevant government requirements and that these programmes, in planning the size of the training institutions, consider also the staff needs of secular medical work offering opportunity for Christian witness and service.

5. Similar consideration should be given to the training of paramedical workers.

6. Because of the vital role held by the hospital chaplain in the healing team special attention needs to be given to his selection and specialized training.

7. Involvement in organized Christian medical work must be regarded as a speciality in itself. Specific provisions need to be made to educate the Christian physician, the Christian nurse and other medical workers into the true relationship of their professional practice and the healing task of the whole Christian community. The Consultation recognizes the need for the development of a special joint training programme for physicians, senior nurses, hospital administrators and hospital chaplains in preparation for overseas work to acquaint them with the special aspects of medical service in developing countries, familiarize them with the team approach in Christian healing and to assist them to make their professional service relevant to the cultural setting of the given area of their future labour.

8. The church should encourage suitably qualified members to accept teaching positions in universities, medical colleges, nurses, schools, and similar secular institutions of learning as a special challenge to Christian witness in teaching.

VI THE INSTITUTIONAL FORMS OF A HEALING MINISTRY

1. If we are to accept the premise that Christian healing is an integral part of congregational life, it will be necessary to study first the role of the medical institution within this context and, secondly, to see how far other forms of medical service are relevant and necessary.

2. We must first confess that the medical institution and the church on the national and, more particularly on the local, level have travelled too often in separate directions. While the hospital or clinic may have substantially aided in the initial creation of a congregation, it has usually failed to commend itself as a continuing expression of that congregation's healing concern.

3. The time is long overdue for the complete integration of the hospital and clinic into the life and witness of the church. This should not be taken simply as meaning that the administrative control of the institution should be within the power of the local congregation, since this is often undesirable, but it does mean that the congregation must recognize itself as the healing community which knows the hospital to be an essential channel of its witness to the world. The doctor, the nurse and other hospital personnel are only a specialized section of a team which is the People of God in each local situation performing its healing ministry. Where there appears to be no evidence or potential understanding of this integration of healing function, the continuance of the institution must be seriously questioned.

4. The size of a medical institution should never exceed what is necessary for its established purpose or the capacity of the total Christian community supporting it and ministering through it. Whatever the size of the institution, it should always have a teaching function appropriate to its size and local needs.

5. We recommend, as pilot projects within selected hospitals, the initiation of a team concept of therapy wherein the physician, nurse, psychiatrist and pastoral counsellor should unite to treate the patient in the totality of his sickness.

6. Other forms of service through which the church should continue to express its healing ministry lie in the fields of leprosy, tuberculosis, care of the chronically ill and aged, rehabilitation, psychiatry and maternal and child health. There still exist many areas for pioneering service in rural health as well as inner-city clinics which, for more adequate therapy, should be linked to a central hospital which need not necessarily be church-related. It is especially in these areas that the congregation can assist in domiciliary care and in health education through practice and precept.

7. The pattern of institutional therapy has too long prevailed in the church to the detriment of the intimate relationship between patient and doctor in the general practice situation. The healing congregation might well involve its doctor members in this new relationship and challenge their response and commitment.

8. Finally it should be stressed that professional competence is an effective part of a Christian witness, and medical work of the institution or other forms of service should neither continue nor be projected if it fails in this respect. The church must always recognize that it can never meet all of need and should regard new avenues of service as demonstrations of how need should be met. It is also desirable that there should be an integrated witness in which medical work may be correlated with social work, nutrition and agricultural and community development.

VII THE RELATIONSHIP OF A CHRISTIAN HEALING MINISTRY TO GOVERNMENT

1. In cooperation between church and government, many valuable forms of service present themselves. These lie particularly in the fields of health education, nursing and paramedical training programmes and the extension of rural clinics and public health. It is recommended that, in planning for future work, we should always seek government cooperation for the closer integration of health and medical services within the area. However, the Christian concept of healing as we have defined it may sometimes necessitate the continuance of existing institutions or the development of new ones which may appear superfluous to a government health plan which takes no account of this understanding of healing.

2. The Consultation favours cooperation with government and secular agencies, provided this in no way compromises our understanding of a Christian healing ministry. Particular care must be taken with respect to this where such agencies are approached for financial aid. In recent years we have seen the extension of such aid outside the once familiar relationship which used to bind one country to another. Care will need to be exercised that the solicitation and receipt of such funds should not jeopardize the integrity of Christian witness and the relationship between the local church and the government of its country. Nor should the receipt of such funds ever release the church from its own obligation to support the project.

VIII JOINT PLANNING AND USE OF RESOURCES FOR THE HEALING MINISTRY

1. To an increasing extent, financial resources are being allocated without regard to denominational lines.

The Consultation recognizes that the resources of funds and personnel for the healing ministry are not equally available in all countries to all operating agencies. The Consultation, therefore, gratefully notes the considerable degree to which financial resources are being allocated through ecumenical channels according to need and opportunity.

2. The interdenominational assignment of medical missionary personnel should be encouraged.

The Consultation further notes with appreciation

the instances of, if not trends toward, interdenominational placement of available personnel to meet urgent needs. This procedure requires more effective organization than is presently available.

3. The churches are not sufficiently aware of the urgent need for joint planning.

The Consultation believes that churches in all parts of the world, at the local, regional and national levels, must increasingly join together in survey, study and planning for the most efficient and effective carrying out of the healing ministry. In all localities and regions, such joint planning will make more effective each individual church's medical ministry. Beyond this, in some places it may be desirable not only to plan together, but to conduct additional united medical programmes.

4. The involvement of the congregation in the ministry of healing demands a reappraisal of existing cooperative structures.

It is not clear whether such bodies as Christian medical associations, related or unrelated to national councils, are the most effective structures for joint planning and action. How can such associations be so related to the churches that they may aid in the fuller expression of the healing ministry in the congregational setting? Should some other cooperative structures be planned, which would be more appropriate to the healing ministry of the Christian community?

IX A CONTINUING PROGRAMME OF STUDY AND WORK

The complex of theological and practical problems relating to the church's healing ministry requires three kinds of continuing work if there is to be some progress made in finding valid Christian solutions to the many issues before the church.

I. The first is an effective gathering, analyzing and making generally available of the very large amount of work in survey and study that has been done and is in progress around the world.

It is recommended that DWME, in cooperation with other divisions of the WCC, make provision for the systematic handling of this in as far as funds and facilities permit.

II. The second is the encouragement of study and survey at local, regional and international levels.

A. *It is recommended* that WCC/Division of World Mission and Evangelism and the Committee for Specialised Assistance to Social Projects sponsor a series of studies, surveys and consultations on the healing ministry, particularly from the perspective of the lands of the "younger churches", and that the Commission on World Mission of the Lutheran World Federation, the Advisory Council on Missionary Strategy of the Anglican Communion, and other Christian bodies concerned with these issues be invited to participate in this process.

B. *It is recommended* that a particular attention be given to the following issues:

1. The theology of health and healing.

   Specifically, it is hoped that:

   a) churches and groups now working in this area of theology will be encouraged;

   b) at an early date, perhaps in 1965, a small consultation of theologians be called to discuss the subject "Health and Salvation" from an exegetical and systematic point of view.

2. The relationship of church and state in the area of healing and health.

3. The relationship of the church's ministry of healing to private practice of medicine.

4. Joint action by the churches in the ministry of healing, particularly in relation to medical missions. Such study must be based on factual surveys, which for maximum effectiveness could be much more fully coordinated in both planning and execution than is now the case. It is recommended that surveys be carried out by teams which should include both local and outside people.

   It is specifically recommended that:

   a) steps be taken for the provision of advice and counsel and the development of uniform principles which would be offered to those initiating surveys;

   b) when so requested, the WCC undertake to assist with both local and regional surveys.

III. The third is the carrying out of pilot and experimental projects in an integrated programme of healing.

It is recognized that such experiments in a number of forms are now being undertaken in various parts of the world.

It is recommended that churches should work together where desirable on further experiments, based on the principles of a full Christian healing ministry.

MEDICAL AND THEOLOGICAL PERSPECTIVES ON HEALTH TÜBINGEN II, 1967

In the tradition set by the gathering of Tübingen I three years before, the second Consultation on the churches' commitment to health work was again sponsored by the World Council of Churches and the Lutheran World Federation. In September of 1967, it brought together 27 participants from 10 countries for 8 days of dynamic exchange. This second Consultation directed itself explicitly to the task of healing wherever the church lives, rather than confining itself to the work of medical missions. It profited greatly by the presence of official Roman Catholic representation.

Various papers were developed during the course of this Consultation as positional statements arising out of the discussion. These reflections covered many subjects from a theological perspective, such as *The Nature and Meaning of Illness and Suffering, The Place of Suffering in the Promise of the Gospel, Interpersonal Relationships,* and *Death and the Christian.* The participants spent a good deal of time exploring *The Task of the Congregation in Relation to Health,* and seven papers emerged from that discussion. A third group of reports covered aspects of *Medicine and the Church.*

This Report was printed and distributed and a few of the papers were also published in the **International Review of Mission**, vol. LVII, no. 226, April 1968 (WCC, Geneva). At present, both of these documents are out of print. The Christian Medical Commission plans to reprint all of the papers of this Consultation in mid-year 1979 to make them available for those interested in further study. This publication will also appear as a number in the CONTACT Special Series.

SECULAR AND CHRISTIAN MODELS OF HEALTH AND SALVATION

by Dr R. A. Lambourne

This article was originally delivered as a lecture in 1969. It was first printed as CONTACT 1, November 1970.

In this presentation, I have three things in my mind and there are links between them. There is a crisis in medicine to the point at which some people are saying that healing lies outside the medical profession, and that doctors are the ones who oppose true health. There is a crisis for the church, with some saying that the real church lies outside the church. And there is a crisis in the consciousness of many Christian doctors, nurses, teachers and social workers who believe there is truth in Christ, in the Bible and Christian religion, and yet find that what seems to enlighten them in their chosen work and in their personal lives is something else; hence they go through life divided.

1. CHRISTIAN OBEDIENCE AND A NEW VISION OF HEALTH CARE

Now, I want to make a very sweeping theological statement about the nature of true knowledge which is based upon a biblical theory of revelation which I think applies to all forms of knowledge, including medical and social work. The general pattern in the Old Testament is that God reveals to His people what is truth, what is true knowledge about themselves, what is just, what is good, what is health, and what He is. But God always does this to a people in a particular place, at a particular time. So, having true knowledge for their day of what it is to be healthy, what it is to be man, what it is to be godly, is related to the obedience of the people at that particular time. True knowledge for tomorrow, God's recurrent self-revelation, is dependent on being obedient to what they know today. If they are not obedient to what they can already know, they become blinded to the truth for tomorrow. If, for example, knowing the statistics about the health care delivery system of their country, say, in terms of infant mortality and the distribution of doctors, they don't take notice to construct a proper health service, then the understanding of what good medicine is will be distorted. If, on the other hand, they are obedient, if they will listen and learn, then they will know what is good medicine tomorrow. If people don't do this, God closes their eyes and stops their ears, and they don't see the truth until the wrath of God descends upon them, and their nation, their medical system, their social work system and their church is broken. Obedience, purity of heart, and righteousness, and true knowledge are all inseparable. The connections between them may be subtle and complex, but they are always there.

In the New Testament you will find that Christ promises His presence, His real presence, when His people do things in His name: you visited me in prison, came to me in the downtown area, gave me an antithyphoid injection, etc. So, Christ links His real presence as much to such acts as He does to the Holy Communion. And in the Bible this real presence and God's self-revelation is always linked with knowledge and power in regard to matters of good and evil, to health and disease. Again truth and obedience are linked together.

It is not good our saying something with our lips and preaching another gospel with our health care delivery system. Our Lord didn't say with His lips that all men were loved by God and then do healing miracles with the rich alone. Had He done that, everyone would have noted the incompatibility. What He said and what He did was a unity; otherwise there would be no church today.

Of all acts, those appertaining to the body-person are existentially those most close to the Gospel acts. There is nothing so ultimate and so immediate as acts around your body-person. In a sense, the final injustice, the ultimate injustice, is injustice of health care. If your neighbour has a bigger house than you, it may not be just, but you can live in a small house. If your neighbour has a big car and you have to walk, it is unjust; or if your neighbour can eat cake and fancy food and you have to get by on scraps, that's bad. But it is nothing compared to whether

your neighbour has an unfair consumption of health care. If you are in a position to gobble up the health care which would have saved your neighbour's life, then this shows the ultimate injustice. So, what you might call body-person communism, or communalism, is the most radical of all communalisms, much more important than any other property communism. So, if you want to preach the Gospel of God's infinite love and care for all people, your health care system may eventually be the Gospel you actually preach and which is actually heard. Body care is incarnated words, and that is why it is so central to the preaching of the Gospel. So, neither health care nor the church can show preference to the wealthy or to those who live in towns close to where doctors choose to live for their own convenience. If they do, then the incarnated words they produce in the form of health care is a gospel which is not true to Christ.

2. THE NEED FOR CONTINUOUS REAPPRAISAL OF HEALTH CARE CONCEPTS

In medical missions there are some 2000 church-related hospitals in the world. But hospital medicine is getting too expensive, and this produces a crisis and provides an opportunity for Christian obedience leading to a new vision of what health and health care are. However, like all crises of obedience, to respond positively to it provokes positive misunderstanding – what the Bible describes as a blinding of the eyes and a stopping up of the ears. This crisis in medicine then provides an opportunity of learning a new understanding of what it is to be healthy, a new understanding of how to give health care. God works in a mysterious way His wonders to perform.

He is trying to teach us all new ways of thinking and doing. The old ways which have to be changed are related to certain concepts of medicine all of which were defined in terms of the hospital and in terms of individual diagnosis and treatment. We may note in passing that the priest and the church have closely related defects because they commonly define the excellence of Christian life almost exclusively in terms of church attendance with a view to the eradication of moral lesions from the individual concerned through the activity of the professional Christian, namely, the priest.

To illustrate how far things have gone in this stereotyping of certain concepts of excellence in medicine, here are two examples. There is one developing country where 60 per cent of the budget for health care is spent in operating one large teaching hospital. Again, I was in the USA when some medical students with a social conscience revolted because they were appalled at working and being taught in one of the most advanced medical centres in the world, whilst they were literally within a stone's throw of the downtown area where people weren't getting any medical care. The medical students refused to be taught any more and went out and began giving health care. Although this health care was, in terms of the hospital, less skilled, it was in fact more excellent in terms of its ultimate result of the relief of suffering than that the hospital was giving.

Again, there was a man who went to a famous paediatric hospital in Africa which had been in existence for fifty years and the people and church were proud of it, for every child who came to the hospital received the best treatment. Then this new paediatrician came, no more devoted nor less a Christian than the previous one; but he looked at the infant mortality rate in the area served by the hospital and discovered that it hadn't altered at all over the years. It was about 282 per 1 000 and would stay that high as long as excellent medicine was practised in the hospital! It wasn't hard for him to discover that the children were dying of three diseases, A, B and C. One was malaria. If you can talk to the people, feel the spleen and give a tablet R, by and large you can put the matter right. Another disease was some kind of dysentery; by talking to the people, having a rough look at the stool, if you can persuade the child's mother to give tablet S it will cure the disease in most cases. The third disease, I think, was sores; and again it was not very difficult to solve the problem, provided you are willing to make mistakes in diagnosis, but you have to be willing to make mistakes. This paediatrician had been taught back home that individual excellence of diagnosis is the mark of a doctor, but he had to produce, first in himself and then in others, doctors who had excellence suitable to the job required of them. Therefore, he took a few girls out of the local mission school, aged about fifteen taught them and sent them into the villages. They made an enormous number of mistakes, some of them disastrous from the traditional medical point of view. He was fortunate there wasn't a strong medical or nursing professional organization and there wasn't a legal system where they could sue for wrong diagnosis. But in five years' time the infant mortality dropped to 78 per 1000. Now what was killing all those children before? A sacred, stereotyped view of excellence! That is, a graven image of excellence, tempting us to idolatry.

We must make it clear that there is no ideal medicine, no ideal way of being a doctor, either up in the sky or in the teaching hospitals of the West, waiting to be blueprinted on the nations of the world, no more than there are a series of true propositions about God, the universal acceptance of which will mark salvation of the world. Doctor excellence is situational. Each tomorrow reveals the nature of the excellence required, whilst at the same time, just as we think we have grasped it, the next tomorrow requires us to learn again a new understanding of excellence.

Time and time again we come up against the problem in ourselves and others of needing to change our understanding of the professional image of excellence to the Christian view of excellence. In this matter we must note and take account of the psychological fact that one's view of oneself, one's professional identity, tends to be formed and become fixed in one's life during the training period. This is why in general it is wise to put young people in a professional educational system in situations where they form a professional identity which is reasonably relevant to the general task that society needs them to do. In spite of this fact, we still go on in most countries, on the one hand knowing that we need community nurses and doctors, and yet on the other still training them in situations where they are least likely to form a suitable professional identity. I was recently in a city in the Philippines and met a young Christian doctor who said he was going to be a neurosurgeon. His boss, whom he very properly admired, is a neurosurgeon and he very naturally wants not only to be like his boss, but be better. That's quite understandable for the young man, but it is tragic because he is now fixed on a course of being excellent as a Christian and a doctor which is not relevant to his original chosen task which was to cure people. He will go to America, because that's where the most excellent neurosurgeons work, for his further training, and this will make it quite impossible for him to work anywhere in the Philippines but in Manila, and perhaps not even there. If by any chance he later hears a call from God to go and work in the rural districts, he will have to fight his professional identity, his built-in concept of excellent doctoring, for the rest of his life.

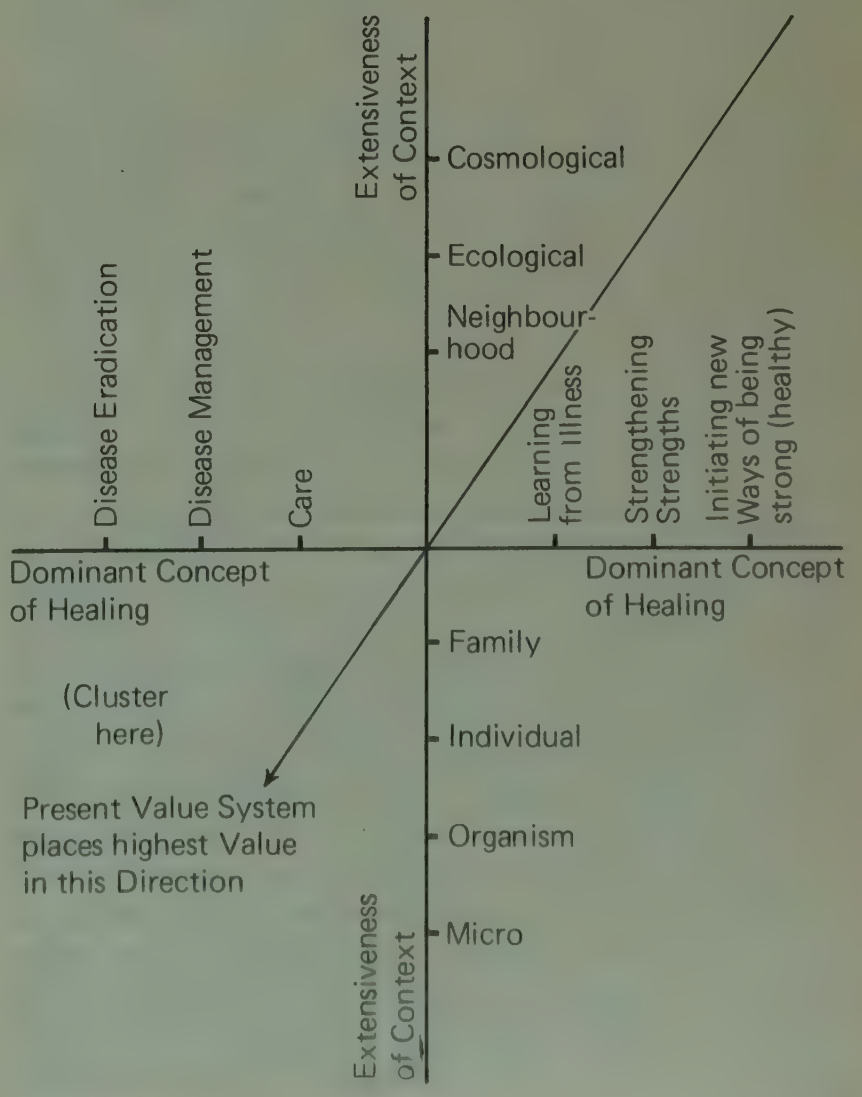
3. HEALTH CARE CONCEPTS VIEWED ALONG TWO CONTINUUMS: EXTENSIVENESS OF CONTEXT AND VIEWS OF THE HEALING PROCESS

Now I want to introduce you to a map which I call a concept map, which is applicable to the church, to medicine and social work, amongst other things. The idea of a map is to help people to see where they are, where they might go, and to suggest the nature of the territory, so that if they were to move from one place to another they can get some idea of what they should do. There are many maps, and one could pick the wrong map, but look at this map and try to learn from it, whilst not letting it become an idol.

A lot of people in medicine and in the church, besides myself, have been saying that they want fewer doctors doing highly specialized work; rather they want more doctors doing community care. They are saying the kind of person they want deals less with individual patients and works more out in the community helping it to discover its own strengths and building them up. The church is beginning to realize this and perhaps should want individuals to be less concerned with their own individual salvation and more prepared to find health with others in the mission of assisting others to find health together.

In the Health Map the vertical line records the extensiveness of the context within which we think about health, and this context grows bigger as you go upwards. At the lower end of this vertical line is the *micro* level, and it is with this concept that the molecular biologist and the cell pathologist, amongst others, do their work. Next on the vertical line, going upwards, is the *body organism* which is the conceptual context of the doctor who, by and large, works at the body organ level, i.e., for example, specializes on the heart, kidney or bone. Next, going upwards, is the use of the *individual* or person as the extent of context within which the professional person works, and we can associate this with the doctor who works in internal medicine or perhaps with the psychiatrist who works largely with the individual. A little higher up, about half-way and in the middle of the concept map, you have the *family* which we can associate perhaps more with the paediatrician or the child psychologist who see more than one person as the unit of context of which it is proper to speak of health or disease. So, for example, such people presented with a child said to be suffering with nocturnal enuresis, a speech defect or asthma will probably want to ask questions about the mother and father and their relationship to each other and to the child also.

Health Map



Next on the vertical line is the *neighbourhood* which is getting very much into the area of epidemiology, public health, infectious diseases and mental health. Professional people working in these specialities can envisage health or disease as functions of a whole neighbourhood. Then next comes the *ecological,* and now the extensiveness of the context is much expanded. It was the failure to work within such a suitably extensive concept of health that sometimes caused a disaster. In developing countries, when doctors worked by simply extracting disease, wherever it came their way, only to realize too late that they had not taken a wide enough view and, for example, looked at the food supplies of the increased population they had created, so that thereby medicine might be said to have caused disaster. Note that in the ecological concept of healing we have to include the educational, political and economic concepts of health. Thus it is that the thinking and knowledge required to be an effective doctor working with this extensiveness of the concept of health becomes more clear and complex. You can't do good medicine at this level without being, for example, a politician. The same truth goes for the social worker and the theologian.

Then, at the top of the vertical line, comes the *cosmological* where not only the whole present geographical world, but the whole future world is included. What this means is not too clear, but take the instance of congenital diabetics whom we keep alive, who then reproduce so that the number of congenital diabetics increases, and we begin to see that in this way, as in many others, we have to consider — in our understanding of health and disease — factors which go far, far beyond the present.

Finally, right up off the vertical line is an absolutely, totally extended context within which disease and health is to be understood, and we as Christians believe it is within this context that God alone understands good and evil, health and disease, suffering and joy.

On the horizontal line on the map we put in a position of dominant views of what the healing process looks like, each one of which is associated with a particular kind of professional person. Let me interject at this point that we need people working with every one of these concepts, and if at some time I seem to favour one rather than the other, it is not that I do not think that each one has his own quite specific part to play, but rather that I am complaining that a proper balance does not exist at the moment. We begin at the left with the concept of healing as *disease eradication.* This is the concept of healing with which, wherever you see evil in the form of disease or sin, wherever it comes in front of you, you pluck it out; the surgeon is the most eminent example of using this concept of healing as being essentially disease eradication. Historically speaking, it is not surprising that this concept predominates in medicine when you remember that the first breakthroughs in medical science came through morbid anatomy and histology both of which literally see disease as a focal lesion in an inanimate context. The dominance of this surgical concept of healing, perfectly appropriate in its own place, is now our main problem. Let me point out that this doesn't mean I am suggesting that every kind of medical person is not needed. Of course, for example, we need neurosurgeons. The question rather is, shall the neurosurgeon and other surgical models dominate medicine so that it produces an imbalance of ideas and of professional people, with the result that many, many members of our communities go without the medical care they require?

The next concept of healing on the horizontal line is *disease management* which still enrols the concept of disease eradication but suggests that you must take more notice of the person you have to manage. However, the concept of healing as disease management may still be only a sophisticated way of achieving the goal of disease extraction.

Care is the next concept on the horizontal line. Care is not traditionally so much a medical as a nursing concept. There has been a tendency of recent years, especially for this care, to become the work of lower classes in the healing profession. So it is becoming increasingly difficult to get care for somebody who can't be cured. For the prestige in our age goes to that person who is nearest that doctor who is curing people by disease extraction. The least prestige, the least money, the least self-satisfaction goes to the person who cares for those who cannot be cured. In fact, care nowadays tends to be validated only by its efficacy to cure. So caring in itself and for itself is a virtue under attack these days and, consequently, often in order to keep people caring and to get people to do this kind of work, you may have to make them look as if they are curing. One time in my life I had three years looking after chronic schizophrenics and doing nothing else. I was in desperate straits because it was so contrary to my professional image which was built up on curing people, occasionally at least. Now, if you have that kind of professional image requiring the cure of people, if only occasionally, then you are going to be sick to the point of desperation if none of the people you care for are cured. So it is that in order to keep up the morale on the chronic wards, every now and then people had to be given ECT, even when the statistics show there is no point in giving electric shock therapy for them. And yet, in fact, it was good in a very dubious way, because it restored the morale of the doctors and nurses, and with the morale restored they could then continue to care; and since caring is very important to keep the place human, the ECT was effective, although wrong! By making almost an idolatry of disease extraction we have depreciated the act of caring as a good thing in itself.

The next concept of healing on the horizontal line is *learning from illness* which is a very old concept. It speaks of the possibility of good being born by the transformation of evil. There are medical analogues of this traditional religious concept in which the body is strengthened by the "experience" of "badness". Consider, for example, a vaccination or when antibiotics are deliberately delayed in order to allow immunity to be built up in the person. It is my personal view of neurotic illness that the indiscriminate use of the disease-eradication model of healing is disastrous and that we should concentrate on the concept of healing as creating the capacity to become healthy through the proper experience of stress.

The next concept, progressing to the right on the horizontal line of the map, is the *strengthening of strengths* in order to try to increase the already present strengths which enable the person or the other unit of context to cope. For instance, there are two ways to help an adolescent: analyze his problems, searching for one key, one which supposedly causes his disease, and then eradicating it like a tumour, or strengthening his present virtues and capacities for enjoyment and thus giving him greater ego-strength. This idea of strengthening present strengths and building up on that is a concept of healing which has been lost to medicine until recently, but it was always preserved in the practice of teaching where, by and large, one does not look so much for defects in the pupil but for capacities which can be encouraged and developed.

The last concept on the horizontal line of the map is the invention of new strengths. This is presenting to a nation, a people, a church and individual a new way of being alive, a new way of being happy, a new way of enjoying food, a new way of dancing, a new way of making love, a new way of being a political nation, a new way of playing football. Some of our most up-to-date planners of comprehensive health care don't seem to realize that their plans may be quite upset unless the country discovers a way of being a people which is health-giving for the plans proposed. We have already pointed out how improvements in health care require the discovery of a new way of being a doctor, a new way of being a nurse, a new way of being a patient.

At one time I was the medical officer to an infantry battalion. In the final analysis I was not responsible for the health of the soldiers which was in fact the responsibility of the commanding officer. I've said we must contextualize health, and here is an example of the statement that being healthy is to be understood in part as being the member of a community with an appropriate purpose. The commanding officer was quite probably not interested in medical conditions in the sense of the classical diagnoses of the individual soldier's diseases. He was interested in whether a soldier could march twenty miles with a bren gun in order to fight an enemy and thus participate in the purpose of the community in which he was a person. We cannot divorce the concept of health and disease from the understanding of the purposes and therefore the nature of health of the community to which the person concerned belongs. We have done with disease the same thing that we did with sins and have talked about them and acted towards them as though the important thing in the church is to help individuals to get over sins as an end in itself and have forgotten that the whole purpose is not the eradication of sins themselves but the transformation of the person in order that he may love God and his neighbour. If Jesus had made His own individual health for itself the supreme sign of excellence, He could not possibly have gone to the Cross. His understanding of His own health was related to His understanding of His messianic purpose. The concept of my own health for myself as an unqualified good, as something to be pursued without question, is unquestionably demonic, just as is the concept of salvation as something for myself.

4. THE IMPLICATION OF INDIVIDUAL VS. COMMUNAL THEOLOGIES OF SALVATION/SIN AND HEALTH/DISEASE FOR MEDICAL AND PASTORAL TRAINING AND FOR CHRISTIAN MEDICAL ETHICS

Whenever I have spoken of disease so far, or shown the concept of healing on the concept map, you could always substitute the concept of sin. There is a particular theology of sins which exclusively regards them as being realities localized in the individual which can be enumerated and spoken of as if they existed in themselves. In this view, sin is not situational, or between people, or between man and God, but is a reality in itself inside an individual. Just as in the bottom left-hand corner of our concept map, disease is seen as distinct realities having their existence solely in individual bodies. Now, you have heard of situational ethics, sometimes called contextual ethics. At the beginning of this talk I asserted that the biblical theology of revelation is that God always reveals Himself again and again. There is not a universal propositional theology. So, too, there is not a universal medicine: excellent medicine in the USA is not necessarily excellent medicine in Hong Kong, or Korea, and so on, just as in situational ethics we understand that there is no easy way of telling the truth, nor any one way of being a perfect sexual person, so we say the same of being the obedient excellent doctor. So, at the back of this concept map is a theology. Our Lord reveals this theology most particularly because in Him God reveals Himself through a particular person and at a particular time. This is why there is a big catch in "The Imitation of Christ," because one cannot be a kind of blueprint or photocopy of Him – rather we have to discover in each generation

what it is to follow Christ. We cannot safely imitate Him in the sense of just doing what He did anymore than the young man should imitate the way his teacher, the neurosurgeon was a good doctor.

I want to remind you that this map has things to say to the Christian. It is very likely that there is a relation between the way medicine has grown up to see disease and to act towards it as if it were a local lesion in an individual, partly under the influence of a particular kind of Protestant ethic which puts supreme value on individual salvation and sees that salvation in the eradication of sins within oneself. It has been said that modern, hospital-centred, disease-eradicating medicine is a memorial to all the strengths and all the weaknesses brought in our day by a combination of Protestantism, empiricism and capitalism. The division of the world into sacred and secular, with the partition of the care of people into the care of the soul by priests and the care of the body by doctors, produced two professions which in some senses can be seen as mirror images of each other. Thus it is that the weaknesses and strengths of each reinforce each other and that dialogue between doctors and theologians may confirm each other, not only in their strengths but in their prejudices. So, for example, of recent years there has been a tendency for the church in training to send its young ministers to the medical man for practical experience to make up for their lack of knowledge of the world, without appreciating that this might reinforce some defects as well as strengths. So it is that after receiving clinical pastoral training many young ministers decided not to go into parish work, which is based upon a whole variety of concepts of saving and has strong community and educational content within it, but decided that they must set up an office and become clinical pastoral counsellors waiting in their office for people to come in with a defect, a disease to be cured, just as the doctors do. For this reason the pastoral counselling curriculum must be modified or we may damage young ministers for life by their training, just as we can damage young doctors, and make them permanently unsuitable for commitment to enabling work for the whole life of the whole community.

Students, whether medical or theological, should surely have their vital training with an emphasis upon the community which balances the clinical emphasis which up till now has been on the individual level. They should go during their training to different kinds of neighbourhoods and, thus, there be taught by people the copying of whose excellence will be suitable. These will be people who, in part, have to work with the complex decisions involving not just medicine but politics, economics and sociology, for example. They must, we can say, learn skills based upon concepts in all the areas marked out by our concept map and not just at the bottom left-hand corner. There must be a balance between individual care and communal care, and a balance between interest in health and an interest in disease. There must be as much skill in joining a group of people and enabling them in discovering a distinctive way of being healthy as there is in sitting in an office waiting for individuals to come with particular problems to be solved. One of the great problems of putting pastoral training under the influence of psychoanalysis and thus of the pastoral counselling movement is that the whole way of life is determined by working with sick people, so that, as a result, health is seen as absence of sickness and never as a failure of persons together finding what it is to be fully human.

Finally, a few words about what this means for medical ethics and for Christian ethical decision. Our whole present medical understanding and Christian understanding requires that we spend great sums for the treatment of one person, whereas if we could reapply the expenditure we could save many lives. The real, the new, the excellent humans of tomorrow, will at a certain point be required to say, "No, this cannot be done," and "This particular person has to be sacrificed." This makes clear what has always been true but often been denied, namely, that the practice of medicine is an ethico-political art. What we have been discussing today reminds us that many of the major ethical decisions confronting the Christian doctor are not those involved in the choice between different acts towards the one patient in front of us, such as when to pull out the intravenous tube or stop artificial respiration, but a kind of political decision involved in health care planning which decides quite literally whether thousands of people would live or die. The young man from the Philippines, who made the decision to be a neurosurgeon, was at one and the same time deciding that a few people with brain tumors would live but hundreds, if not thousands, of others with different diseases in his own rural area must die.

Finally, how much health care should a Christian consume? We all recognize that there are limits to the amount of money and food which we are entitled to have when others are in poverty or starving. Yet, in the United Kingdom and other countries, we are willing to draw doctors into our lands from developing countries. We are willing to pull doctors into London where the doctor proportion is one for each 400 persons from, say, Central Africa where the proportion is one for 50,000 persons. What kind of morality is it where we are consuming the health care of others? Health justice is more radical than any other kind of justice. In order for us to live from 70 to 72 years of age, shall we bring doctors from a country where the average lifespan is 35? Now, when we say, "Stop doing this kind of thing, stop squandering health care of the individual", very often we get the reply that human life is sacred, and theology and biblical quotations are used to support the present practice; but this we must remember — that the person is

sacred to God within God's divine purpose, which is to bring all men to Him. There is nothing sacred about an individual's longevity in itself. There is nothing sacred about an individual being able to swallow up great quantities of health care. Life in the Bible is not sacred in itself but is sacred within the purposes of God to bring all human beings to fellowship with each other and communion with Himself. Maybe in the future, groups of Christians will come to say that bringing doctors from developing countries into highly affluent countries is a modern equivalent of the slave trade of three centuries ago. This is an area where human beings are being called to be more responsible; this is an area in which God is revealing Himself anew and teaching us new ways of being made perfect.

CHAPTER IV:

MORAL ISSUES AND HEALTH CARE

by Dr John H. Bryant and Professor David Jenkins

This paper represents the first stage of a dialogue which took place between Dr Bryant and Professor Jenkins at the annual meetings of the Christian Medical Commission. It was the basis for discussions in the meeting of August 1969, and was first printed in CONTACT 4, July 1971.

BRYANT:

The moral issues involved in caring for individual patients are well known and often discussed. But the moral issues associated with providing health care for large numbers of people, particularly when resources are severely limited, are less well appreciated. The lack of understanding of these issues — indeed, the failure to recognize that they exist — is a serious obstacle to improving health care, whether provided by a government health service, university or church.

The Conditions Under Which The Issues Will Be Faced

Understanding the questions involved requires, first, understanding the circumstances in which health care decisions must be made. Throughout the developing world, national ratios of doctors to population range between 1:3000, as in Latin America, to nearly 1:20,000, as in Africa. But most of the population is rural where professional personnel are scarce, perhaps one physician and one nurse for every 10,000 to 1,000,000 people. 1:50,000 is an approximate average. Governmental money available for health care varies from $.20 per person per year in Indonesia to over $10 in some Latin American countries. The use of this money is not well distributed, and most of the population is served with well under $1 per person per year. Thus throughout the developing world, one physician, one nurse and a variable number of paramedical and auxiliary personnel try to provide health care for more than 50,000 with a budget of less than $1 per person per year.

A population of 50,000 rural people will live in about 8000 homes in several hundred communities distributed over hundreds of square miles of land. In a year there would be over 500 deaths and 2000 births. Health facilities would be visited by about 350 outpatients per day, and there would be five hospital admissions (a continuous requirement for about 60 hospital beds). The people would be afflicted by disease conditions that are both curable and preventable, but cure requires effective contact with competent health care, and prevention requires effective programmes reaching into communities and homes. As examples of these conditions, obstructed labour requires immediate care by a physician in a well-equipped hospital or health centre, and malnutrition, parasitism, and overly large families require changes in the ways people live their lives.

Let us consider the work of the physician responsible for providing health care under such circumstances. His/her role will vary according to the work setting: the diseases and the conditions under which they occur; the extent to which resources are available; the system providing health care; the capabilities and limitations of other members of the health team.

The use of auxiliaries, for example, has considerable influence on the role of the physician. The style of the physician's action will be very different in a country such as Kenya where there is a wide range of auxiliaries compared with, say, a Latin American country where auxiliaries are scarcely used and nurses are in short supply. In the former, the physician has an organized team to be led against the health problems. In the latter, it may be necessary to develop both the team and the organization in order to strike at those problems. But whatever the differences in the circumstances of work, needs will exceed resources, and the physician have difficult choices to make in analyzing the problems and attempting to develop effective solutions. At the centre of these difficulties, if recognized, will be some crucial decisions on moral issues.

We can move closer to these problems by joining a young government physician arriving at a first assignment. He/she has just finished an internship

and has been assigned to serve — as the only doctor — in a rural district which is 20 miles wide and 30 miles long and contains about 70,000 people. The hospital has 70 beds, and there are 110 patients. The nurse — there is only one — shows the new physician around.

A large crowd is in the outpatient clinic, and the physician learns that 200 to 400 patients come each day. Two medical assistants are looking after them. The doctor will be asked to see the difficult problems. Just walking by, malnutrition, anaemia, skin problems and eye diseases are obvious. The hospital is clean and well kept. A midwife is taking care of two women in labour; no complications. There is an X-ray machine that will probably work when the tube is replaced. There is no X-ray technician; someone will have to be taught. The pharmacy is neat but poorly stocked; of the last drug order they received no penicillin and only half the chloroquin. This is an area where infection is common and malaria is endemic.

The refrigerator is not working. A little lab has a small microscope, a hand-driven centrifuge and some unlabelled stains. There is no technician, but one of the medical assistants has expressed an interest in brushing up on his microscopy and working in the lab. The operating theatre is simple and adequate. The medical assistant who had been giving anaesthesia was transferred, but one of the others would be happy to learn. The nurse could give rag-and-bottle ether anaesthesia if needed.

The staff of the hospital consists of the doctor, the nurse, two midwives, two auxiliary nurses, four medical assistants, and various ancillary personnel including two drivers. The office of the District Health Inspector adjoins the hospital. In this district are four health centres, each staffed with auxiliaries, and each has a Land Rover, though these are occasionally grounded for lack of petrol.

As they look around, the nursing sister tells the new doctor of a new patient, a woman who has been in obstructed labour for two days and now has the signs of a ruptured uterus. The operating theatre is ready if needed. The regional hospital with a surgeon is 140 dirt-road miles away.

The medical assistants are having difficulty setting a shattered fracture of the leg. A boy is comatose with what they believe to be cerebral malaria; his father is a local chief of considerable importance. The traditional healer from the village is with the boy now. A message was received last week from a medical assistant at one of the health centres about two cases with fever, headache and mental confusion — it could be sleeping sickness.

For Whom Am I Responsible?

Now let us examine the kinds of decisions to be made by the new doctor. One is central to all others: For whom am I responsible? For whom shall I provide health care? Those who come to the hospital? Those who come to the health centre? Am I responsible for those who do not come? The importance of this question is increased by our knowledge that those who are in greatest need of health care may not know their need, or they may know it but may not seek health care.

The "whom" question almost invariably involves a moral choice, though it is seldom appreciated as such. The underlying reasons for our deciding whom we will serve are often obscured by traditions of medical care. Medical personnel in a hospital, whether associated with a university, mission, or government, usually accept as a matter of course that they will serve those who come for care but not those who do not come. This health care is often the product of devoted and selfless service carried out under extremely difficult circumstances, and it would not occur to many that this approach needs justification — it seems to be self-justifying.

This "non-choice" approach to determining who should receive health care has dominated most medical care institutions and is now coming under increasingly heavy criticism. At the centre of the criticism and of the answers to the criticism should be some attempt to define the purposes of the institution. For the mission, is it evangelism? Is it service? If service is meant to be a substantial part of the mission's purpose, what kind of service should it be, and how should it be measured or evaluated? In terms of numbers of people treated? In terms of improvement in health? (Contact between people and health care programmes does not necessarily result in improvement in health.)

Thus, to our question, Whom should we serve? , is added the question, How should they be served? In examining these questions, it is useful to recognize a dimension of responsibility that lies on governments that does not usually lie on missions and universities — *the responsibility for a defined population.* There are technical and ethical issues that are sharpened by examining health care programmes in a context that includes responsibility for a defined population, be it for all the people of a nation, a district, or of a community.

The basic equation that must be taken into account in every health care situation is that resources are always limited relative to need. If those responsible for health care have the prerogative of limiting the size of the population to be served, either by decision or default, they are, to that extent, released from the constraint of resource limitations.

Shall resources be used to provide some care for all, or better care for a few? The question applies at all levels: to a single physician with a health team

serving a district; to the director of a programme of tuberculosis or leprosy; to the planners of an entire health service. The issue centres not so much on the size of the decision maker's universe as on whether or not the responsibilities are considered to extend to all the people of that universe. If they are thus taken into account, the need to use resources to cover those people with maximum benefit is accepted. If they are not, then by that decision and to that extent, the restriction of resources is evaded. The physician can, for example, double or quadruple the per capita expenditure of a programme simply by deciding to serve only one-half or one-fourth of the population in its universe.

Notice how the decision of the physician to accept responsibility for all the people of the district can shape all other health care decisions. Let us assume that the major objective established is to improve the health of all the people of the district, and methods are available for measuring that improvement. It is immediately clear that those who do not come to the clinic or hospital "count" in the calculations of improvement as much as those who do come. Indeed, if the responsibility for all is accepted, every step of health care must be judged against the need of all and must be divided by the same denominator — all the people. How does one judge an expensive programme that improves the nutrition of 30 children when 3 000 in the district are malnourished?

Whom To Serve And Whom To Deprive?

An effort to provide a certain level of health services for all people, regardless of where or how they live, has its inappropriate extremes. Resources might be spread so thinly as to be of little benefit to anybody. Thus once the physician has decided to serve the entire population of a district, it must be decided whom within that population can actually be benefited. This is not an empty exercise in logic — to insist that the physician accept responsibility for all, even though it is impossible to care for all. Only when responsibility for all has been accepted can their needs be analyzed, and can those most in need and those who can be effectively served be identified.

The physician may find, for example, that more than 50 per cent of the pre-school children are malnourished; that only 20 per cent of women are receiving antenatal and obstetrical care; that most of the population has hook-worm; that the birthrate is over 40; that the leading causes of childhood death are malnutrition and gastroenteritis, and of adult death malaria.

As the physician designs action programmes to meet these problems, it becomes quickly apparent that available resources will allow an attack on some but not all the problems. Priorities must be set, perhaps with malnutrition and the lack of antenatal and obstetrical care at the top of the list. But even within these priorities, not all can be reached and, therefore, smaller targets must be chosen, say, the most severely malnourished children and the mothers who are at greatest obstetrical risk.*

Now we are at the heart of the matter. *In making these decisions, the physician is deciding who shall be served and who shall be deprived, and is at the same time deciding who shall live and who shall die or be disabled.* By what criteria is this decision made? What value system guides the choice of whether to try to improve the health of the mothers, or the children? Which children? Or the old? Or the fathers? Or those who can contribute most to the nation's GNP?

We have constructed a situation in which the burden of moral decision is on a single physician. Is it realistic to expect that one person, a physician, will have the social morality to guide these decisions? Should the government provide directives on these matters? What if no such directives are forthcoming? If the physician represents a church, should the church provide the directives?

Are these questions answerable? Is it socially and politically feasible to make choices publicly that involve serving some and depriving others when human life is involved? Currently these "choices" are seldom made. Rather, as noted earlier, traditions of health care determine who is served, and the rest are deprived by default rather than as a result of studied choice.

The Technology Of Problem Solving

Economists, systems analysts, and health planners are developing techniques for solving complex problems such as these, and while these techniques are highly useful, they do not circumvent the unanswered moral questions.

Systems analysis begins with a careful description of the "system" under consideration, in this instance, a rural district with its health problems, including all components of the system, their interrelationships, and the external factors or constraints that influence the system. The major challenges or problems of the system are indentified and placed in an order of priority. In attempting to solve the priority problems, objectives of the solution must be defined together with a means of measuring the extent to which the objectives are attained. Alternative

---

* Notice, however, that to identify who is malnourished and who is at greatest risk requires surveying the entire population.

solutions of programmes are designed, and each is characterized in terms of its costs and the benefits that would result from its implementation. By comparing costs and benefits, the decision maker can choose from among the alternatives and proceed with implementation and evaluation. If problems are highly complex, teams of experts will work through these steps together, assisted by a computer if that is needed.

What must not be missed in this whirl of technological elegance is that, while this analytical process facilitates decision making, decisions must still be made. Indeed, by systematizing the process, some choices are laid bare that may not otherwise be seen:

> Deciding which problems should be given priority is the first step toward serving some people in the population rather than others, presumably those who are in greatest need and can benefit from a particular health care programme.
>
> Setting the objectives of programmes directed toward a particular problem involves asking the question, "Of all those affected by this problem, who should be included in the target group and what can be done for them? "
>
> For each problem alternative solutions or programmes are developed and a choice is made from among them by comparing the costs and benefits associated with each, but on what scale of values are "cost" and "benefit" defined?

Economists usually define cost in terms of monetary investment and benefit in terms of returns on the investment. Thus cost in health programmes would involve personnel, equipment, medications, and supplies (including the costs of producing them), most of which can be converted to monetary terms. Benefit, or "pay-off", would be the return of the investment, measured perhaps in terms of decreased death rate, which can be expressed in terms of increased labour productivity. For the economist, the ultimate measure of investment in health might be the extent to which the investment adds to the nation's GNP.

But there are many examples of health legislation that do not follow these guidelines. The most recent legislation in the USA has been to provide health care for the old, the poor, and mothers and children. In the economist's terms, the most favourable cost-benefit relationships would come from health programmes directed toward the non-poor, working-age population. Clearly the law-makers in the USA were not using the economist's definition of "benefit".

What criteria should be used? What is the theological equivalent of "benefit" in the cost-benefit equation of health care? Increase in labour productivity? Decrease in misery? An intact family? Would it have more to do with the quality of life than with the length of it? Whose life?

Statistical Morality

For some who are accustomed to thinking of health needs in terms of individual patients cared for in a hospital setting by physicians and nurses, with the devotion, gratitude, and human intimacy that implies, this discussion of the quantitative needs of people, which can often be expressed only in statistical terms, may seem arid and dehumanized. The point is, of course, that our exclusive interest in medical care for individuals often results in the neglect of many times that number. Perhaps we need what Warren Weaver spoke of as *statistical compassion.* What is the theological equivalent of statistical compassion?

The technology of health care is entering an era in which diverse talents and creativity are focusing on the problems of providing health care for large numbers of people on limited resources. Is it possible to match these developments with moral and theological concepts that will give the decision maker of tomorrow a system of human values to fit into the technological methodology utilized?

A number of governments are concerned about these issues because they recognize their formal responsibility for the health care of all their people, but the actions of governments are limited by political, historical and administrative constraints. Churches, on the other hand, have not generally accepted formal responsibility for the health care of defined populations and have therefore avoided some of the difficult moral questions discussed here. But churches have the potential of wisdom, human concern, commitment and flexibility to develop a social morality of health care. Will they do so?

JENKINS: THEOLOGICAL COMMENTS ON THE ISSUES RAISED BY JOHN BRYANT

Dr Bryant's paper seems to me to be a practically perfect example of the sort of challenge which theology needs to face if it is to regain its proper relevance and effectiveness. The paper is factually located (i.e., distilled from the practical questions arising out of the experience of particular problems in actually experienced situations) and pointedly organized so as to raise very clear questions. The underlying situation which is made explicit throughout the paper seems to be the awareness that the routines of my discipline and its tradition (in this case the medical) are not enough. I am faced inevitably with wider questions than this routine and tradition answer. These questions face me when I attempt seriously to live as a human being and for

other people. Thus I discover that individual compassion is not enough, and I have to ask myself, "What of statistical compassion?" Developments in my discipline, in my environment, and in the general understanding and experience of the human situation thus face us with such questions as that of Dr Bryant's, "Is it possible to match these developments with moral and theological concepts that will give the decision maker of tomorrow a system of human values to fit into the technological methodology used?"

"The situation ... of having to face hitherto unexperienced questions and challenges is the normal condition of the People of God."

Dr Bryant discusses his situation and poses his problem from a medical point of view, but the first thing to be clear about is that the situation which he describes is generally true. We are all moved out of our familiar surroundings. As he has said, the truth is that no one is competent in the area with which the Commission has to deal. This is because we are all being taken into new and unknown country – which leads me to my first theological comment. This situation of not knowing where we are and of having to face hitherto unexperienced questions and challenges is the normal condition of the People of God. *We are a wayfaring people.* We must not be afraid of the fact that problems do not have solutions but simply resolutions into the next set of problems. We are engaged on a journey, we are involved in a process, and we need to be absolutely clear both about this and about the great anxiety which this basic feature of our living so often causes. There is the anxiety of those who do not want to move at all, there is the anxiety of those who do not know how to move, and there is the frustration of those who are prevented from moving by these anxieties of others. In actual practice, we probably all embody all these anxieties and frustrations in differing degrees. The first point, therefore, is to be clear about this situation and that it is a normal one, reflected in the biblical understanding of the People of God, so that we do not need to be anxious about our anxieties, frightened by our fears, or stultified by our frustrations.

"Theology is concerned with drawing on our understanding of God in relation to (problem) situations."

We have, therefore, to ask ourselves whether we can get any sense of the *direction* of the journey and *what resources* we may have for this journey. It must be stressed that this is an essentially practical problem which leads us to moral and theological issues. What help can we get from theology? Our answer to this question will depend on our understanding of theology and of the proper way of "doing theology". By theology I mean the practice of drawing on our understanding of God for our living, deciding, and hoping. Theology, as I understand it, does not work a priori but it works in response to situations. In my view, although this may upset Dr Bryant, his paper is a profoundly theological one because it presents the shape of a particular human situation and reflects this situation in a way which raises pointed questions about our understanding of ourselves in relation to one another, in relation to the world, and in relation to God, supposing that He exists. This reflects what I believe to be the biblical picture of the way the wayfaring People of God do their theology, i.e. receive and make use of their understanding of God. God is to be found where the action is, where the questions arise. The knowledge of God comes about through facing the realities of the situation and the challenges of the questions. Thus my second theological point is that on our journey as the wayfaring People of God, theology is concerned with drawing on our understanding of God in relation to situations. Here it seems appropriate to comment on the phrase in Dr Bryant's paper about "the technology of problem solving". As I understand it, technology is to do with problem solving. but theology is to do with living with problems. Hence there cannot be a simple positive answer to the question of Dr Bryant, which I have already quoted, about matching theological answers to problems raised by technology. Theology, I believe, is concerned with "the practice of transcendence in the midst". That is to say, theology is always pointing us to the claimed fact that the only final fulfilment of man is to be found in God and that, therefore, we must always be living towards an infinitude of God. Theology, if its basic faith and insight is true to itself, understands in a particular way what all perceptive human beings have understood, which is that no solution to our various problems is or can be human enough. If I may relapse into simple statements of faith, only God is a sufficient context for human beings, only God holds things together, only God brings in the Kingdom. The practical effect of this is that we are always living with problems and on our way to the End which we do not yet enjoy or attain.

"... God in Christ puts us on to something vital concerning the life of the person."

Here we come up against the third main point which I consider Dr Bryant's paper obliges us as a Commission to face. Do we clearly and firmly accept the sort of thing reflected in what I have called the "simple statements of faith" made at the end of the last paragraph? Do we believe as a basis for our approach that God in Christ has put us on to something true and vital, something which is essential with regard to human living? This is the question of the *differentia* which has kept coming up in our discussion. What are the distinctive things which make the difference between our being a *Christian* Medical Commission and any other sort of

medical commission? The answer, as I understand it, lies in the area of our understanding and faith that God in Christ puts us on to something essential for the life of people. If we do not firmly and clearly believe this, we should operate elsewhere. We have to be able to understand ourselves in a manner different from those who may still hold the view that the Christian Church has sufficient command of resources to be made use of at the present time, but that it is simply to be exploited until its obsolescence causes its final disappearance. We do not have to refuse to work with people who simply want our resources but reject our faith (e.g. in setting up local health services), for I do not think that followers of Jesus Christ can insist on better terms than He did for working with and for people. Jesus cares for people solely on the basis of His love and makes no condition. Similarly, our work of caring and serving has to go ahead without our making conditions, but *we* must not lose sight of our "differentia" as Christians. We have to be clear about what is given to us in faith and about the challenge both to and of that faith. Therefore, I said that Dr Bryant's paper reminds us of the answer which we must give to the question, "Why *Christian* Medical Commission?" My brief answer to this question is, "Because God in Christ puts us on to something vital concerning the life of people."

"Our responsibility is to all but it is not in the same sense for all."

But this brings us to our next question which is, "What is this 'something'?" Here we come back to my first and second points. We have to find out what this something is as we live in the process and face our questions. It is a mistake to suppose that we can know what the something is and then face the questions. What we have to do is to live in the situations and with the questions, and to do this by drawing on the Christian resources, the Bible, the church, the communities of Christians, the life of prayer and worship, and so on. As we seek to do this, we may discover such things as the following for example. In his paper, Dr Bryant writes, "Only when the physician has accepted responsibility for all can their needs be analyzed, can those most in need, and those who can be served effectively be identified". The point about responsibility is clearly, rightly raised. I think, however, that the Christian resources would question the way in which, and the context within which, it is raised. The Christian understanding and experience of humans and their situations would seem to be saying to us that while we are to be aware of responsibilities *to* all, we are not responsible *for* all. The only way in which this total and unlimited responsibility is to be accepted, or can be accepted, is in and through God. This is very important from the practical point of view because, for example, of the danger of omnipotent fantasies and their reverse, sheer despair, in people who have professional responsibilities for caring for people. Professionals are liable to feel that unless they deal with problems, the problems will not be dealt with. This is not only a practically impossible deduction, but it also distorts the way in which problems get looked at. I think that here we are on the verge of great theological depth. The Cross shows us that only God is capable of fully accepting responsibility for all. Our responsibility is to all, but it is not in the same sense for all. It is under God. Otherwise, our responsibility cannot be put into a practical perspective, into a truly spiritual perspective, the sort of perspective which enables us to cope with our human responsibility and to remain open. Without the "under God" sooner or later we will define our responsibility in a particular way and, therefore, make our responsibility less than human, because a total responsibility needs always to be an open responsibility and not a defined one. Thus we need resources to live uncomfortably, but not despairingly, with our responsibilities and to be set free for making particular definitions and decisions for practical purpose within this open responsibility.

"... many of the questions will not be answerable but ... nonetheless we must raise them."

Another area, going on from this one of responsibility, with regard to which we may consider the effect of making use of Christian resources, is the one touched on by Dr Bryant when he asks: "Are these questions answerable?" I think that the theological understanding that I am suggesting shows that, in a sense, many of the questions will not be answerable, but that nonetheless we must raise them. There is a clear risk and a clear cost involved here, but we are facing extensions of our responsibility required of us as human beings under God, and we need to be sustained under God in facing this cost. This is bringing us closer to what the Cross both involves and makes possible. The other example can be taken from the very suggestive discussion which includes the phrase "statistical compassion". We are asked, "What is the theological equivalent of statistical compassion?" I believe that there is only the love of God which cares for everybody and can cope with the numbers involved. But this caring is precisely not statistical but a caring for persons, for individuals. Hence we are liable to find ourselves caught in a tension between individual compassion and "statistical compassion". The very phrase is a useful formula, because it is really a contradiction in terms and thus shows us our problems with which we have to live. Further, in facing this and all our problems, we have to go on to facing the problem and reality of evil. To be realistic one has to face the fact that no amount of compassion — statistical or other — will stop us dying, nor in present conditions will it stop immense numbers of people dying in conditions which acutely deny their humanity.

Moreover, it is no good our pretending that any technological scheme will work as we suppose it would, or produce only the effects we suppose it should. I draw attention to these points not for pessimistic reasons but for realistic and optimistic ones. We have to face the fact that any scheme will not have strict limitations but will sometimes have disastrous ones and that there are disasters which no scheme can avoid. But in the light of the Cross and of the Resurrection, we know that we have no grounds for giving up hope. Clearly, there is very much more to be said and argued here, but I would just draw the general conclusion that the theological and indeed the Christian activity is precisely to raise and face this type of question for the sake of being human.

"... we need to recognize 'the poor' and see how they can alert us to our priorities."

But we must proceed to the next and practically most important point. This talk of raising and facing questions is all very well, but nonetheless we all have to decide what to do. So what shall I do? Here I think that we have to be clear that for each one of us in our respective situations the agony of the decision is our own. We cannot be freed from this, and we have to understand that this agony and uncertainty and faultiness of taking decisions is one of the ways in which we share in the life and the suffering of Christ. Nobody other than the person in the situation can decide, but we must still ask what help can we give and receive in this situation. For example, what about the question of priorities raised by Dr Bryant? Clearly, this needs discussion at length, but one suggestion which it occurs to me to make is that we must consider the significance of the *poor.* I think that biblically the poor are very significant in throwing into relief those features of society on which the judgement of God falls (compare for example the prophetic denunciations of the treatment of the poor in, e.g., Amos and consider also the significance of the humble and hidden faithfulness of the poor which lies behind the reference to the poor in the Beatitudes). Thus I would suggest that we need to recognize "the poor" and see how they can alert us to our priorities, if we are to respond in a Christian way to the needs of our societies. For example, in this matter of health care, it would seem to me that, theologically speaking, a vital criterion could be obtained by asking in this field, "Who are those who are not cared for and to whose care no prestige is attached?" These are not necessarily the poor in any simple economic sense, but rather the neglected, the ignored, the unimportant, the rejected, the outcasts and dropouts of society at all levels. The fact that any society produces them is itself a judgement upon that society and its priorities, and our priority is to get these priorities changed. I think we have to be clear that the Christian calling is to *stand in* society by *standing out* against the distortions, neglects and ignorances of that society. This will mean that in our actual decision taking we always find ourselves in tension. Our temptation is to attempt to free ourselves from this tension and thus fail to do our Christian job. We can stop raising questions about the tasks society sets us, pretend that we are practical people and get on with our job, but that is to acquiesce in the dehumanizing aspect of our society. The other way is to say that we are faced with questions which are too difficult, and so we must get out of the job we are in. But that is just to run away from our Christian opportunity. We have, therefore, to stay in, often be uncomfortable, often cause discomfort. For instance, we have to be clear ourselves and make it clear to others that no amount of health care will stop people from dying either now or then. Therefore, our decisions have to be made about how we help people to be human in the light of (1) their need for health care, and (2) the need to treat them as human beings who live *and die.* Something has to be brought to them here and now, whether or not we can change their overall condition. There is need to remove malnutrition and to face the problem of caring for undernourished people who will die. No amount of development will give people *human* life and will only help them on the way.

"We must challenge prestige and what is taken for granted, and ... not imagine that we can offer health, only enable it."

I think, incidentally, that this criterion of the "poor" should directly help us about our Christian priorities with regard to the setting up of a comprehensive health care service. Where there is a pioneering need to do this, because nobody else will give attention to it, then it is a Christian calling. Where other people are already doing it, then it is not specifically a Christian calling. There may be, of course, reasons why a particular institution should cooperate in it. But our particular concern is to care for those who are not cared for.

Then I should say that a second criterion develops from the criterion of the question of the poor. This is the need to question that which is taken for granted. For example, how far is the use of medical personnel and resources in fact directed by a traditional prestige which has been built up? The important thing is to have more and more equipment and to be able to do more and more interesting and complicated operations, for example. Who is going to bear the burden of constantly challenging this sort of thing and to go against the grain of his/her profession? This is a very important part of the calling to follow the suffering Christ and to challenge and correct priorities. Further, there is a need to question assumptions about the very idea of health, especially the notion that you can deliver or impose health. Who are we to take decisions about health and especially to impose our notions of

health? God is the Giver of health and salvation, and not me, and it is the good purpose of God to sum up all things in Christ. This means, I think, to enable Africans to be as African as they possibly can be, Chinese as Chinese as they can be, and to set us "whites" free to be what we can be and then to discover what richness comes out of it all. We must, therefore, be very careful about imposing our idea of health on somebody else. We are always in grave danger of serving ourselves and our image of ourselves rather than those we claim to serve. Health is something to do with the wholeness of all and cannot be imposed from above or from outside. We are not concerned to produce health but to enable health so that the Giver of health may give it. It is in this light that we should always be ready, for example, to question any taken-for-granted policy about setting up hospitals without taking into account the real needs of the area to be served. We have to be clear that this sort of service and questioning with regard to priorities is liable either to provoke explosive situations or else to lead us into frustrated situations; but this is all part of our calling.

I would summarize my points as follows:

(1) We are in a wayfaring situation, and this is normal for the People of God.

(2) Theology does not provide answers but enables us to face questions, to choose questions and put them in perspective.

(3) We have to pay particular attention to the differentia of faith in God through Christ.

(4) We can thus draw on the Christian resources which enable us to face responsibility in and for the processes of change under God.

(5) The poor can provide us with one important and decisive criterion concerning priorities.

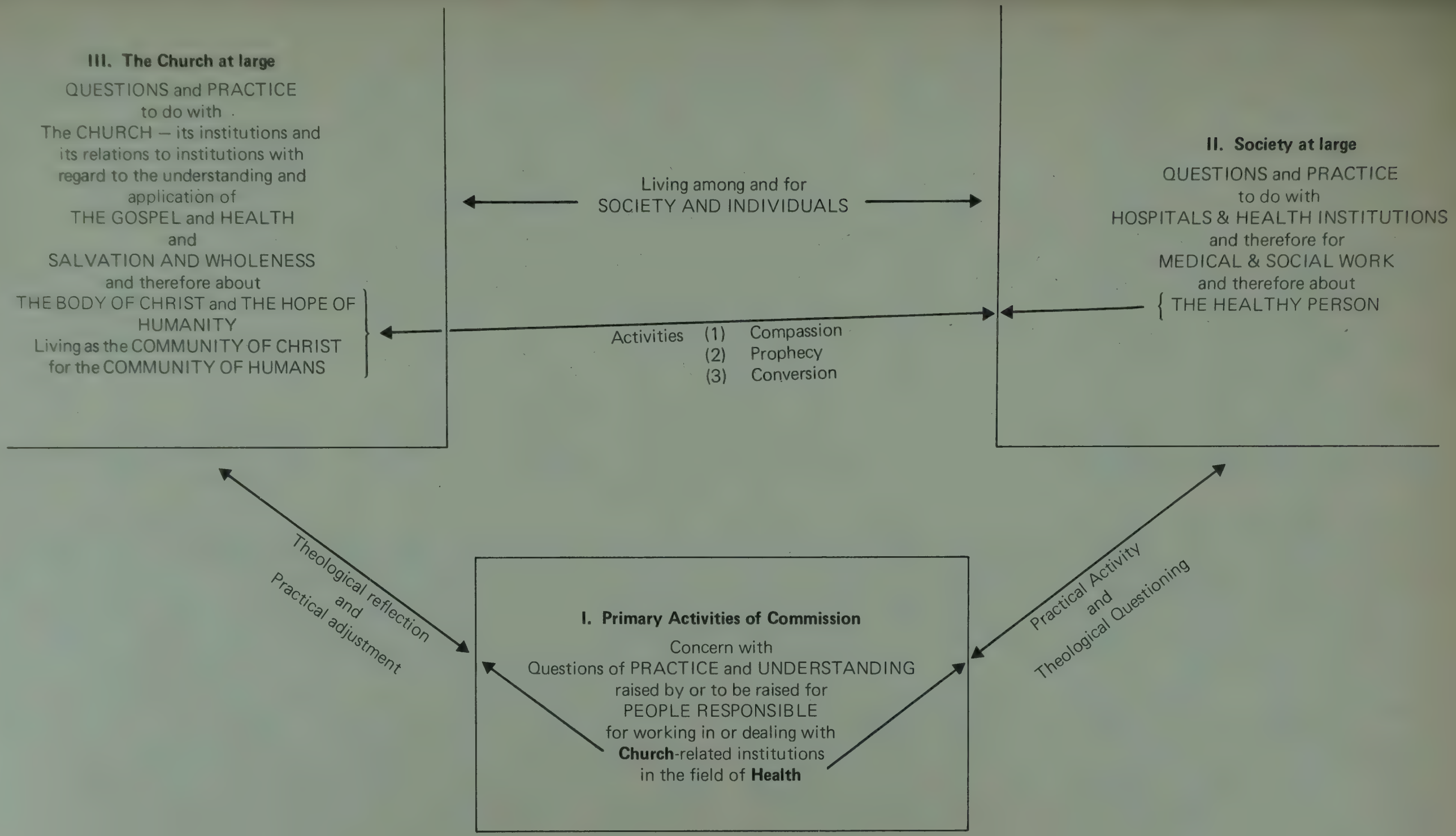
(6) We must challenge prestige and what is taken for granted, and we must not imagine that we can offer health, only enable it.

The Work of The CMC.

I wish to finish my remarks by suggesting a possible working model for understanding the activities of the Christian Medical Commission which seems to me consistent with the points outlined above. I have summarized this suggestion in the attached diagram which is meant to exemplify working from particular situations and doing theology within and out of those situations. The situation of the CMC is that its primary activities have to do with those working in church-related institutions in the field of health or in relation to concerns for health. But any such working raises questions both on the side of health and society in general and with regard to the life of the church in general. We are thus bound up in what may be called a circuit of ideas, decisions and practices which interrelate health and church institutions and activities and questions concerning our understanding of and working for the healthy person. Since these questions can become so vast and all-embracing, it is very necessary to be clear that the Commission must concentrate in what I have called area one and work here in awareness of and with a concern for problems and practices in areas two and three. I believe the theological call is always to work with the activities into which one has been called in awareness of the wider area which one therefore must face. One cannot, however, wait for clarification of questions in the wider areas or changes of practice in those areas before taking decision in one's area of primary concern. All one can do is to attempt to promote a creative feedback between the various areas. This is why I have linked the various areas on the diagram with labelled lines and arrows pointing in both directions. The situation is thus complex, but the point of attempting to map some of its complexity is to set us free to work within it.

A proper understanding of theology should certainly give us the freedom we need. We should be aware that, in actual decision, probability must remain the guide of life and that our faith gives us the encouragement to obey Luther's command *Pecca fortiter* (sin boldly) which reminds us, I believe, that we are always free to act, although we know that our acts will be at least imperfect and often truly sinful. Nonetheless, it is in our acts that we seek to respond to God and put ourselves in the position to be used and corrected by God. Our understanding is that it is God who ultimately holds things together and brings them to some worthwhile issue, and not ourselves. Above all, we must expect real newness and so attempt to live and to act in the direction of that newness. All our challenges concerning the poor, priorities and prestige will be challenges concerned with this, and as we are seeking to serve and live as Christians, we shall find that these challenges must develop three different aspects. There is the challenge of and to compassion. (Need always requires to be responded to.) But there is also the challenge of and to prophecy. (The structures which produce need and the assumptions about meeting need often have to be spoken against in the light of our understanding of human beings offered to us through Jesus Christ.) And there will be finally the challenge of and to conversion. (It is not necessary simply for people to be "healed" or "restored" or "developed" in order to be fulfilled and fulfilling; we all require to be radically changed.)

In regard to the work of a body like the Christian Medical Commission, we need to remember that a representative group must be non-representative of the body it serves if it is to be of real service in helping them to face and respond to change. However, it must not become so unrepresentative as to get completely out of touch with the body it is



The Christian Medical Commission — its Primary and Consequential Activities and Effects

supposed to serve. Secondly, we must be clear that a fully common and agreed ground for working among a diversity of individuals, of groups, and of individuals exists only in the grave or in heaven. We therefore have to trust one another enough to move in probable directions and to take risks which seem to us worthwhile, and thus grow together. We cannot wait for agreement before we act. We must discover a common life in acting. Certainly, failures and frustration are inevitable. It is always better to do something and thus to get things on the move and so create the necessity to respond to change.

Our Christian theology, that is our Christian understanding of God, demands that we take situation-centred decisions, that we then reflect upon them and that from this reflection we draw repentance. This repentance will be a practical repentance (new thinking about what we should do), personal repentance (new thinking about ourselves), and statistical repentance (new approaches to structures and mass decisions). In the light of all this we shall return to situation-centred decisions and to a new round of action, reflection, and repentance. What we do know is that there is always hope because the resurrection of Jesus Christ following on the Cross of Jesus Christ shows that in our living "if only" has been defeated. It is not the case that we could serve God and humanity *if only* things were different, and *if only* we took better-informed decisions. We can serve God and humanity where we are and as we are.

CHAPTER V:

MORAL ISSUES AND HEALTH CARE — THE CONTINUING DEBATE

by Dr John H. Bryant and Professor David Jenkins

This paper represents the second stage of a two-part dialogue which took place between Dr Bryant and Professor Jenkins at the annual meetings of the Christian Medical Commission. The continuing debate, in the meeting of September 1970, was first printed in CONTACT 4, July 1971.

BRYANT:

Life's Decisive Questions

We continued with the central question: When all cannot be served, how should it be decided whom to serve?

These questions deal with the lives of people, and it must be asked: Of what value are those lives we are deciding about? What is human life for? (Isn't it odd? We spend our lives watching the ebb and flow of the lives of others, spend it so busily that we fail for long periods to ask the most obvious and the most important questions. It may be our human frailty to avoid questioning the obvious unless there is a visible chance of answering.) What are the decisive questions to be asked about human life?

Is life to avoid death? Is life to work hard and contribute to the GNP? Is life to live long with minimum morbidity? Is life to enjoy increasing amounts of material wealth?

Perhaps the most decisive question to ask about life would be: What is the meaning of life? If life had a particular meaning, what would that mean? Would any answer satisfy you? Perhaps not. Indeed, the unanswerability of that question is, in one sense, an answer.

Some may think it ultimate audacity to proceed with this line of enquiry, but since we do not consider it audacious to make decisions or default in making decisions about saving or neglecting the lives of people, we must not consider it audacious to think about the meaning of those lives.

Professor Jenkins and I searched for words that expressed, for us, some sort of meaning for life. We settled on:

belonging
caring
counting
sharing
becoming ... being on the way.

We invite you to add to or detract from this list. The words have three characteristics. First, they reflect the point of view of a person and, at the same time, involve that person with other persons. Second, each word describes an active process. Third, each word connotes uncertainty: Belonging to whom? Caring for whom? Counting with whom or for what? Sharing what or with whom? Becoming what? Being on the way to what?

Thus the list of words suggests that important life values are associated with things personal, not in isolation, but as part of a family or community; they are active and process-oriented rather than static; and they are bathed in uncertainty.

The uncertainty may be the most troublesome and the most important aspect of these thoughts. Where there is uncertainty, there may be anxiety, but there is also hope. Perhaps the central theme of our changing world is reflected in the interplay of uncertainty and hope. But our list of words does not suggest that important life values are to be found by individuals acting as a passive audience to a world in which uncertainty and change are in the hands of either whimsical or deterministic forces. Rather, it suggests that a person finds a meaningful life by participating in the process of moulding the uncertainty and shaping the direction and rate of change. Becoming, being on the way, is to some extent in the individual's own hands, and to that extent the degree of uncertainty and the magnitude of hope are subject to understanding.

Now let us stop for a moment and ask where this enquiry is taking us. Is it helping to answer our problem question? I think it is, but before describing how, let us be clear about what we are doing and why.

We asked specific questions about the health care of

large numbers of people on limited resources. Then we observed that resources are usually so severely limited relative to numbers of people and problems that some must be neglected while others are served. The pressing question became: When not all can be served, how should it be decided who should be served? The question deals ultimately with life values. Consequently, we are searching for ways to describe life values and meanings and have suggested some words that strike us as being descriptive of these values and meanings. Having this description, however limited it may be, we will return to our test question and see if we are helped to answer it.

Making Decisions About Health Problems

We are asking if these values can help us to make decisions on whom to serve when resources are limited; we must therefore enter the process in which those decisions are made and see if these values influence the ways in which we make them. An example of that process is the setting of priorities in health care. Let us consider two methods for setting priorities, one dealing primarily with priorities among health problems, the other with priorities among population groups.

Setting Priorities Among Health Problems

A useful technique for setting priorities among health problems is illustrated in the chart on the next page. Four criteria are used: prevalence, which refers to the frequency with which the problem occurs; seriousness, that is the destructiveness of the problem for individuals and society; community concern, which includes the knowledge, attitudes and feelings of urgency about a problem; and vulnerability to management, which takes into account the availability of methods for managing the problem as well as the costs and effectiveness of applying them.

In the absence of numerical data, these criteria are weighted intuitively, using a scale of + to ++++. A score for each health problem is developed by multiplying the individual weightings. This simple method for setting priorities is used by our medical and nursing students as they work in rural Thailand.*

Notice that the method is oriented toward health problems rather than population groups. Particular groups are implicitly involved in some instances — malnutrition is largely a problem of small children, and pregnancy involves only women, but otherwise the method does not take into account special population groups. It does not, for example, lend itself to criteria that might be suggested by the development economist, such as that health care priority be given to males between 15 and 50 because of the contribution of their labour to the GNP.

Choosing Target Populations

Setting priorities among health problems has two limitations in helping us decide whom to serve when all cannot be served. First, as noted above, it does not take into account special population groups; second, even when one wants to aim at a specific disease, resources may be inadequate to care for all who have that disease.

Malnutrition may be given high priority, but if two thirds of pre-school children are malnourished, resources might be adequate to care only for those who are most malnourished.

Death and disability due to complications of pregnancy and childbirth is a serious problem throughout the developing world. If resources will allow only 25 per cent of pregnant women to receive care, which 25 per cent should it be? Currently, it is usually those who come to health facilities, whereas the argument can be made that it should be the 25 per cent who are most threatened by pregnancy and childbirth.

The concept emerges of a system for searching through the population for those most in need, i.e. those already afflicted or those most threatened (the "high-risk" group) by priority problems, and bringing limited resources to bear on their problems.* The system could be directed toward a particular problem, i.e. the women most threatened or at highest risk due to pregnancy, or toward special population groups, such as afflicted or high-risk individuals among the children, labourers, village leaders, or the poor, depending on the criteria chosen.

---

* A limitation of this approach is the lack of quantitation, as would be supplied by true prevalence figures and cost-benefit data. Advantages are that such data are often not available and, further, that this approach requires intuitive evaluation of criteria that might not otherwise be examined on the assumption that they were adequately expressed by the data provided.

* Methods for detecting target individuals must be simple enough and inexpensive enough to fit into the existing health care resources. Auxiliary midwives, for example, can apply simple criteria for identifying malnourished children and women who are high risk with regard to pregnancy. David Morley has discussed a similar approach in his brilliantly simple article, "The Role of the Midwife in Providing Child Care", WHO unpub. doc. (MCH/Midwife/10.65, Geneva, Oct. 1965).

Criteria For Building Priorities

Health Problems	Prevalence	Seriousness	Community Concern	Vulnerability To Management	Totals**
Overly large and poorly-spaced families	++++	++++	+++	++	96
Inadequate antenatal and obstetrical care	++++	++	++	+++	48
Malnutrition	+++	+++	++	++	36
Needs for medical care	++	++	++++	++	32
Communicable diseases of children	+	++++	++	++	16
Specific diseases:					
Malaria	+	+++	+++	++	18
Venereal disease	++	++	++	++	16
Dental problems	++++	+	++	++	16
Tuberculosis	+	+++	++	++	12
Leprosy	+	++	+++	+	6
Common cold*	+	+	+	+	1
Yaws*	-	++	+++	++++	0

* Added to test scoring method.

** Score developed by multiplying +'s. Notice that multiplying is necessary to remove problems with low prevalence (yaws) and low vulnerability (common cold) from priority contention.

Where Do Life Values Come In?

These techniques offer a framework for choosing whom to serve when all cannot be served, and some criteria of choice are included. But are those the criteria we want? We should not mistake the method for the value system. How do human values fit into this technological framework? Let us consider how the list of words relating to life values, introduced earlier, relates to these methods.

Belonging to a family and a community, caring for them, counting for something with them, sharing with them in becoming, in being on the way — as expressions of things that are meaningful in life — suggest that a special value might be placed on the nuclear family, i.e. the mother, father, and their children, and on the community and the community structures that protect and support the family. It is in that family and community setting that these words have the most meaning.*

The critical importance of the well-being, even existence, of mothers and fathers to the raising of children, to use that as an illustration, suggests that those diseases that threaten parents of small children might be given high priority. (Here we are reminded of the dismal news that one of the most serious social, economic and health problems of New York City is that 60 per cent of Harlem children live in fatherless families. Apart from socioeconomic and health implications, the costs of this fatherlessness in terms of human values is incalculable.)

"Becoming" also finds powerful expression in individual potential — a child born into the world, "on the way" to something. While family and community strongly influence what one will become, one's potential for development is also crucial. Crippling diseases, such as trachoma (leading to blindness), leprosy, and malnutrition, can destroy or seriously compromise the potential of the individual for "becoming".

* These ideas would have to be modified somewhat but could still apply to societies in which the concepts of extended families and clan systems prevail.

Thus if the nuclear family, the community, and the development potential of the individual have special life values, it follows that priority setting should take into account health problems that threaten these values.

While these ideas may be neither new nor startling, they appeared to me in a new light. Perhaps I had been too close to the technical criteria of my own discipline. Whatever the reason, I saw them as important and turned to see if they could be incorporated into the technical system.

Working first with the method for setting priorities among health problems, I experimented with changing the meaning of the four criteria so as to include these new concerns and was surprised to find that both "seriousness" and "vulnerability to management" took on added meanings: seriousness, in the sense of the extent to which health problems threatened the nuclear family, the community, and individual development potential; vulnerability, in the sense that contending health programmes are judged in terms of costs and benefits, and "benefit" takes on new meaning. Benefit might previously have been defined in terms of economic return on investment or decrease in mortality or morbidity; now it could be redefined to include the integrity of the family and community and individual development potential.

Another approach to fitting life values into the priority-setting chart that could be experimented with would be to add another column, a fifth criteria, with a title such as "life values".

Turning to the method used for identifying target population groups, the searching system could be tuned more closely to the nuclear family, to people in the community who are critically important to the social processes of that community, and to children in the age groups most susceptible to crippling diseases.

Our purpose here, clearly, is not actually to set priorities or to choose a particular method for doing so, but to consider different ways of fitting human values into a technical system. Notice that in the examples used above, these values took the form of alternative criteria to be considered when making decisions. The procedure for making the decisions was not changed. Now we can look at a different way of making some of these decisions.

Who Should Choose?

Most of us are uncomfortable in working with the issue of choosing whom to serve when all cannot be served. We recognize that we fallible human beings are asked to place a differential value on other human beigns and do not feel technically or morally equipped to do so. It amounts to a revulsion against one set of persons who are distinguished only in terms of training, making nearly sacred judgements about other persons.

Yet health care systems are designed and resources allocated as though such decisions had been made. If these decisions are to be made, who should make them? In a deeply human sense, the only persons permitted to make the decisions would be the persons who themselves are to benefit or be deprived as a result. Our earlier values of belonging, caring, counting, sharing, and becoming, take on a special meaning in the context of members of the community participating in decisions about health care.

In considering the interaction of the health team and the community in making decisions about health matters, two issues should be understood. The first is a matter of ignorance, the second of dependence.

First, the community has a limited, even distorted understanding of health matters, and the health team has a similarly limited and distorted view of the knowledge, aspirations, and capabilities of the community.

Second, the community and the health team are strongly dependent on one another — the community because of its lack of technical skill and knowledge and the need for a focus of guidance toward sensible health care programmes; the health team because the answers to so many health programmes rest with the community, not only because of limited health care resources, but also because programmes such as those aimed at limiting the size and improving the spacing of families and ridding children of malnutrition, require community acceptance.

The Unending Cycle

It would be misleading, however, to think of this interrelationship only in terms of working toward a single set of decisions. Health problems change. Resources change. Programmes require evaluation and change. We see the unending process of working rationally with problems. The steps of the problem-solving cycle, while they might not be so labelled by the community, include defining problems, setting priorities, choosing target populations, defining objectives, developing programmes, evaluating programmes, and cycling again as change is needed or as new problems appear.

The community can be involved at every stage of this problem-solving process, as they are introduced to it, come to understand it, develop the capability for making decisions about it, participate in its application, observe the successes and failures of their decisions, and change it as they decide it needs to be changed. To that extent, they are sharing in being on the way.

The initial objective might be to involve the community in deliberations that would lead to a particular health care programme, but the greater objective would be to establish as an ongoing community process the problem-solving cycle, which might also be called the cycle of self-determination. The decisions made as a result of a community and health team turning through the cycle would be less important than the fact of their involvement in the cycle, less important than the community's deciding what it was becoming.

Professor Jenkins said earlier that, "Technology is to do with problem solving, but theology is to do with living with problems." I wonder if the two are not brought together in this concept of the community's using the problem solving process as a way of living with its problems and for shaping its own destiny, at least to the extent that it can have control over such matters.

True Individuality

Much has been made of the dichotomy of hospital-based programmes serving individuals and out-of-hospital programmes serving communities. The former are criticized for spending too much on too few, the latter for neglecting the needs of individuals and losing the personal warmth (distinctive Christian quality?) inherent in the one-to-one relationships of healing. Doubtless, much has been lost through the mistaken narrowness of these views. There is the middle ground of comprehensive health care through which both individuals and communities can be taken into account as needs are balanced against resources.

But a concept that is important to human values can be lost when we narrowly associate hospitals with the care of individuals, and community programmes with the care of population groups. Some of the most important needs of the individual can be met only in the setting of family and community. Looking again at the words we chose to reflect special life values, there emerges the idea that a person is best able to realize his/her own individuality, to be fulfilled as an individual, when involved with family and community in these processes of belonging, sharing, counting, caring, and becoming.

The Human Side Of Development

Most discussions of national development begin with economics and, unfortunately, may end there. The usual expressions of national development include such parameters as per capita GNP, percentage of age groups in school, miles of telephone wires, and tons of newsprint. We have been considering some life values that rival these economic parameters in importance to people; they may also rival them as definers of development, that is, if we are willing to redefine development.

Obviously, development is an enormously complicated subject, and now is not the time to go very far into those complexities. Nonetheless, in the context of this discussion of human values, there is a place to consider a different way of looking at development, not necessarily as a replacement for existing concepts but as complementary to them and, perhaps, as a challenge to them.

The first step is to turn away from the notion of absolute levels of development and think more in terms of processes, whatever the level. Then we need to recognize that important life values can be expressed in terms of sharing with others the process of being on the way in a direction chosen by those who are on the way. We can then define development in an individual or community sense (and perhaps even in a national sense) in terms of this process of being on the way, noting that this process can be, to some extent, independent of economic parameters of development. It matters less whether a person and his/her family earn $100 or $1000 per year, or are literate or not, than that the individual, family and community are involved in the process of being on the way. A person can be developing in the richest sense — in terms of human values — as a rural farmer in one of the poorest nations of the world.

Can Theology Help Us With Worldly Problems?

Does this discussion help us with the problem of the young physician and the decisions he/she must make? I think it does, and at several levels of the problem.

Visualize this young physician driving a Land Rover over a dirt track in the back areas of a district. Having accepted responsibility for the entire population of that district the physician has turned from the endless stream of people who come to the hospital, leaving them for a time with other members of the health team, in order to oversee the development of programmes in the district as a whole.

In the beginning, the physician and the health team may have sorted out the leading health problems, set priorities and chosen some target populations that could be managed within the slim resources available. In making the choices of whom to serve, help may have been provided in recognizing the limitations of more purely technical criteria. Here, our concern for the value of life, born from a Christian concern and developed in a theological context, provides an example of an alternative set of values to be considered in making decisions about health care priorities.

While this approach to setting priorities may have helped the physician to take into account a wider range of human values, the difficulty, in a purely human sense of one person choosing whom among

other people to serve, has not been lessened. Here, the individual may be helped to recognize that there is a class of decisions that should be shared with those who will be affected by them.

Thus the physician turns to the community. As decisions are shared with them, the long and complex process of their finding their way to effective participation can be seen. But the fact that, apart from the health problems at hand, participation is an important part of the process whereby individuals, families, and communities rise in their capability for self-determination also comes to be understood.

As the young physician approaches a village, shifting to a low gear to move slowly through a cluster of children, and walking toward the midwife from the health team, who stands with the waiting village leaders, his/her purpose becomes evident: to share a process with them that is essential in terms of their health and at the same time humane in terms of their fulfilment as human beings.

In answering the question, "Can theology help us to make decisions on worldly problems?", we should remember the earlier remarks of Prof. Jenkins that theology does not provide answers but enables us to face questions. This discussion helps us with those questions in at least four ways.

First, there is the general point already made that theology helps us to find new ways of looking at questions, helps us to live with questions, and to recognize that the anxiety arising from the uncertainty of living with unanswered questions is the normal condition of our lives.

Second, in the practical matter of making decisions, as the young physician in the rural district must, our discussion contributes an example of an alternative set of values that can be considered in making decisions. New criteria, not answers, are offered. The difficulty of making the decisions, in the sense of the human responsibility involved, has not been lessened.

Third, the discussion contributed a different way of looking at *how* the decisions might be made. Some decisions should be shared with the community, which is not a new concept, but our understanding of the reasons for sharing and the process involved in sharing may have been deepened.

Fourth, the immediate process of sharing decisions is seen to have important long-range implications for the more general process of awakening individuals and communities to their capability for self-determination.

Can theology help us in making decisions about worldly problems? It seems to me that it can, and it is.

But a lay person's question must follow that conclusion. What is emerging from this dialogue is intriguing and, for me, distinctly useful. But is it theology? Concerned people think about human problems and construct useful answers. If these answers are consistent with theological precepts, are they theological? The question may seem naïve, but it is troublesome to lay people who are accustomed to working on social and moral issues without the aid of theology, and it must be a recurring question to those who work at the margin between theology and the secular world.

JENKINS:

The Visible Chance of Something Better

My response to this understanding of the situation goes as follows. Start from the question, "What is the meaning of life?" and the assertion that important life values are associated with things personal. When I came to reconsider the list actually set down at the outset of this paper, I asked myself about the nature of this list and whether, for example, it was a psychological list. It is clear that this was not our intention, as I understand it, certainly not my intention at any rate. The list is not basically psychological, it is theological. For the list is used as one way of referring to the offer of the Gospel, the offer of God in Jesus Christ. The list in my understanding, very imperfectly and for extremely practical purpose, stems from an understanding of this offer of God in Jesus Christ.

Just before giving the list, Dr Bryant inserts the sentence, "It may be our human frailty to avoid questioning the obvious, unless there is a visible chance of answering". To this I would say amen, yes indeed. One of the main problems in getting people to face the implications of identity crises is whether we can offer them something more, something better. It is all very well, I feel, for ecumenical movements, world councils of churches, and even Christian medical commissions, beating people over the head in the interest of the great new Gospel, but busy, frightened, limited men and women are perfectly entitled, it seems to me, to say, "And so what? Come and live with us, and then see how many new questions you can face, instead of flying round the world at our expense to tell us to face questions, none of which you stay with yourself for more than seven and a half minutes." Therefore, the question of the *visible* chance of something better seems to me to be quite central. For us the visible chance is Jesus Christ — the Jesus who was crucified and risen, who is therefore the Christ of God, who therefore puts us on to God the Father, who therefore lives in God the Spirit.

"Belonging", "Caring", "Counting" and "Sharing"

In this light "belonging", for instance, has a whole hinterland of meaning. It means being ultimately,

(and I do not refrain from saying this), being cosmically at home. You are part of, you have the opportunity of becoming part of that which the world is all about. It means being communally at home, belonging. You have the chance of becoming part of the body of Christ, which ultimately is the body of all human beings, which ultimately is the embodiment of all that human beings have it in them to become. You have the chance of individually fitting in, because there is offered to you God, God through Jesus Christ, God through your fellows, God through the world. And belonging really means belonging.

Secondly, consider "caring". Dr Bryant says earlier in this paper: "A person finds a meaningful life by participating in the process of moulding the uncertainty and shaping the direction and rate of change". He qualifies that later on by saying, "... insofar that it is possible for human beings to do so". This I relate to the notion of caring, life is actually about responding to a God who is love. And therefore, caring is not just talking about psychological relationships which will build us up with warm affective movements and motions and all the rest of it, so that we shall, on the whole, feel slightly more cheerful. As a matter of fact, caring is about getting so involved with the realities of human beings that we shall be faced also with aggression, confrontation, contestation, revolution, and so on. But all this is about responding to a God who is love, and when you are talking about caring, you are talking about caring of an immense scope and depth. It is a caring of these dimensions and this potentiality which needs to be constantly broken down and put into the fragments of our lives.

Then again, concerning "counting". On the basis of the Gospel of Jesus Christ, we affirm to everyone, "Indeed you count." What men and women need are experiences of counting, and to count one has to count where one is — count to somebody, count in relation to some decisions that are actually taken, here and now — not solely in relation to "pie in the sky when you die". That is why it is so important to break everything down into particularities. It is no good coming and preaching a Gospel about, "You count in the sight of God" and then thrusting people into queues with a "No you don't want that sort of medicine, that's the sort of medicine you want, get over there! " You have already denied the Gospel in action. But the Gospel affirms that it is literally true that God is given for you, this is what the death of Christ embodies. Hence we must not allow ourselves or other people to have less value than is offered to us by God.

As to "sharing", sharing starts to mean an interpenetration of relationships and possibilities, again where you are. But it is about sharing via God, into all, and it is about sharing through all into God. We are engaged on an infinite quest even in, above all in, our relationships with our neighbours. And "becoming" is to do with becoming a human being in relation to all that belonging, caring, counting, and sharing, while "being on the way" is being on the way to God with God. Therefore, you are assured, in faith, of the resources for, for instance, the reconciliation which is needed. If you are going in for this sort of caring, we are up against all sorts of things. There are the resources for reconciliation, there are the resources for reconstruction, there are resources for the necessary fighting.

Being and Becoming

At the end of his paper Dr Bryant asks: "What is this 'something' which God in Christ puts us onto? " In the first round of the dialogue I deliberately used such a phrase. Now we have reached the point where we have to say the "something" is God himself — "broken down", if I may say so, into all these ways. And so when Dr Bryant asks whether we are doing theology, the answer is that we undoubtedly are because theology is about God. There is a very important practical point here that follows because the "something" is God Himself, because the range of the belonging, becoming, sharing, and so on, is as wide as I have indicated. This is that from the Christian Medical Commission point of view, success and failure are not ultimate criteria. This is also why the mission must be continued. For what one is concerned with is not primarily delivering medicine. Of course, we agree about this, our concern is with delivering health. But in fact, it is not even that. It is not primarily delivering health. What one is concerned with is the business of the intercourse, of the dealing, of God with people, and of people with God, under the forms of, through the processes of, through the opportunities of medical work. And the primary point does lie in this being and becoming.

So that, for instance, the fact that we might fail completely in nine out of ten areas at our first attempt on the matter of comprehensive health care is not grounds for concluding that we have "failed" but would be, rather, ground for coming back and asking, for instance: "What are the criticisms of our concept? ", "How faithful is it to what we are feeling after, in relationships with God and people? ", and then we would set out to try again. It is not a question of whether this will sell, it is not a question primarily of whether this will enable us to keep our hospitals going a little longer. We have to keep our hospitals going, if we do, for *this.* And that seems to me absolutely vital in relation to this most important practical question which has been touched on several times in the discussion. Whatever we do, we must not primarily do it because we are responding to pressures. The pressures are the occasions, but Christianly speaking and humanly speaking they must not be the total cause. Because where the pressures are the total cause, you are

neither human nor Christian. You are just reacting. This is a matter which should be put into every policy assessment for decision. There are, of course, limiting situations; that is to say, situations where pressures build up to so locally decisive a point that action is forced. But it must always be remembered that the limiting cases never define the situation, the total situation.

The Christian Differentia

So, for the Christian approach to situations, the "something more" is ultimately God. In this light, we have to consider further the matter of the Christian differentia. Consider therefore the Incarnation, consider Jesus as the embodiment of God, consider Jesus as the man who is the divine member of the series which is concerned with the becoming divine of all things. Jesus shows that within the historical series the distinctive identity of God is expressed towards us in the identity of a human being. But with regard to this notion of identity, it is important to note further that this God is not the same as a human being. That, indeed, is the source of our hope. The distinctive identity of God is expressed towards us, in the historical series, in the identity of the man Jesus. And it is a human identity which this divine man has. Thus we have the most exciting offer and suggestion, namely, that it is literally true that we have divine possibilities. It is literally true that the stuff of which we and everything are made has divine possibilities. That is the fundamental literal truth about such stuff. That, for example, is why you have got to take the body absolutely seriously. If you know something about the kidneys and you do not make a positive use of this knowledge, you have committed a blasphemy. Or, again, if one fails to pay attention to the realities of bodiliness by going on talking for half an hour when everyone is tired, then one is not only being silly but to some extent being sinful, for no account is being taken of the physiological limitations and possibilities which are involved in our relationships.

With regard to this matter of the differentia, therefore, we have to be clear that we are concerned with what I can only call the mystery of union. Ultimately, this is the mystery of the union of God and humanity. In that mystery of union, God and the human being are not separate, they are made one, but they are not confused. Humanity is fulfilled and God is God. And so also, I believe, in the working of the Spirit, which is what we are all most directly concerned with, because this is God working in us and through us. The Spirit, who is the Holy Spirit, who is God, is certainly in the problems with which we have to deal and the persons who are the essential substance of the problems. But the Spirit is not to be confused with the problems and the persons. There is more than the problems, more than the persons. Therefore it is theologically absolutely sound, totally in accordance with the doctrine of the Trinity, of Christology and Pneumatology to make the attempt to insert and relate the open values about being human into the table to produce a criterion for priorities which will decide what resources you will use in what place for what disease. This is fully in accordance with the whole incarnational, the whole spiritual approach.

But because of the mystery of union, which is to do with no separation, there is a continuing difficulty about differentia. We can never finally settle the question about whether we are being "theological" or not. For to be really "theological" (i.e. concerned with and responding to God), you always have got to be involved in the things, the stuff which constitute the case in hand. Thus Dr Bryant's priority table is about "the stuff", and the stuff or matter is where you find, or have to find, the Spirit and where you have to seek to be obedient to the Spirit. So, of course, it is in here and in relation to this that you have to, in one sense, insert. But you may well come out at the end with a result about which you will wonder whether any reasonably enlightened person might not have come to the same conclusion. You just may not know. What you have to do is get on and find out. The danger will be that you lose the tension over the separateness and the transcendence. To maintain this, you must never settle the question, "Am I a theologian or not? ", just as you must never settle the question, "What is it to be a person? " You may think you know what it is to be a person, but if you think you could know already what it is for me to be me, and for you to be yourself, then you are dead already.

Change — a Revolutionary Path

One example of a practice which may assist to maintain the proper creative tensions in an institutional set-up is the practice of inserting one more question, the question which no one has so far thought to ask, or dared to ask, and which may open up the situation. It may or it may not, but you have to be alert for this one more question. For example, in the training of auxiliaries, are you going to raise the awkward question about why, if you are training them to do medical work, they should not be paid medical salaries? That is, of course, a political decision and much else. All relevant factors have to be taken into account, but what you are looking for is always the one more question which may thrust things open. Here we should, perhaps, warn ourselves that if we are going to go on being Christians, if we are going to maintain a concern to be prophetic in this opening-up sense, then we may well find ourselves involved not in gradual change, in certain situations, but in promoting revolution. We must be clear about this, because if we go from the person to the community and from the community to politics, there may well be hell to pay. At least there may be or there may not be. Again, it depends upon the situation, but we must be clear about it. The degree of reorientation which is required in

certain situations amounts to the need for a revolution. Of course, if we do find ourselves promoting revolution, we will almost certainly be cutting off some funds, but we dare not sell our overall aim for the temporary continuance of a steady income. It is quite clear that what we are talking about is potentially, in some cases at least, either the sort of revolution that gets to work like vinegar in a crack in a rock or that gets to work like dynamite. We may, therefore, well find ourselves committed to what is, in effect, a revolutionary path. But in a way, this is incidental. What we are basically concerned with in Christianity is the celebration of change. This is so because we are concerned with entering into this newness developing into the infinity of Himself which God offers. This, however, brings us to what has been a major point in all our discussions. Change threatens our identity. Therefore, the question is: Where is my human identity, where is our human identity, where is their human identity? In this connection, I am convinced that the ability to sit lightly to our identity is of crucial importance. The more I am involved in systems analysis, in studying the running of institutions, of asking questions about how attitudes which have been institutionalized can be changed, the more the crucial question seems to be: Where do people find their identity? Now, the Christian, the theological answer is that the identity is not in myself as I am now, not in myself, for instance, as a doctor, an administrator, a trainer, a worker in a medical school, an official of a mission board. That is how my identity is expressed and embodied at the moment. But identity is not in the medical profession or whatever else we happen to have solidarity with for the reasons of our training, and so on. Nor is it in our present understanding about churchmanship. It is no good defending one's Christian identity, for example, by "missioning" five souls for the Gospel every week. Nor are we preserving our Christian identity by attempting to promote one revolution every week. Nor is the identity of those with whom we have to deal to be found, for them, in the fact that they are patients, or they are sick, or that they are "on the parish", or whatever it may be. The identity of each and every person is in God and in us all as in His image, and as we are becoming His image.

The great problems of change seem to me to be institutional problems. But the institutional problems are those which trap human beings and to which human beings respond. And unless we can become ourselves persons who are free for reidentification and help others to become such, all this talk about reorientation and so on is quite hopeless. It may well look pretty hopeless anyway, but that is where we go back to belief about the fact that the mission is God's so that we are free to go on trying. Basically, our identity does not lie in any role whatever, in any success whatever, in any failure whatever. We are to be set free to be changed, we have to receive the freedom to do our work humanly. This freedom for change is essential for being human, because if you do nothing but defend the status quo, you get less and less human. And above all, we need to be set free to treat other people as human and not as functions of our organizational roles or our fossilized identities.

Two Practical Footnotes

i) "Sitting Lightly To Identity."

The wider considerations into which the above arguments have led us seem to me to mean that, while dialogues of this sort are important, they are not enough on their own. Several times Dr Bryant sounded the note, "Human values must be brought into the technological framework" – how are we going to fit human values into technological methodology? Now I hope that what I have said shows that I agree that that is one important question. This indeed is a sort of middle question with which, as Christians, we must be concerned. But it is only the middle between three ways, all of which have to be practised. There is another way of taking decisions, and that will be the one in many areas where the Christian differentia and the human differentia probably do not appear at all. I am not absolutely certain about this but, surely, there are a whole lot of questions which must be settled and need to be settled and should be settled, from the point of view of the Gospel of the creation, on straight-forward technical competence. You must not be concerned with the differentia all the time, or you will get scrupulous and irrelevant. You must be concerned with the differentia some of the time, and part of the exercise of being Christian is the reexamination to see when you have not been attending to the differentia when you should have been. But I am inclined to think that trying to fit the differentia in and to relate them is a middle problem. There is a basic problem which goes on all the time, namely, the problem of "getting on with it" with whatever resources available.

On the other hand, there is what I would call the transcendent question as well. It is surely quite clear that, as Christians, we must also be concerned with the transcendent in Himself, if I may dare put it so. And this is where we come back to the question of worship, prayer, contemplation, edification in the church, being built up by attention to the Word of God, and so on. By the transcendent in Himself I, of course, mean God, God as the author of the Gospel. If we are going to practise an involvement, consistent with the Incarnation, if we are going to wrestle with the complexities of all the questions that are properly raised, whenever we face up realistically to the complexities of any field of action, then it is not good to get wholly involved in the questions and in nothing but the questions. They have got to be taken very seriously, but it is not sufficient to be wholly involved in them and in

the relations between the questions and the differentia. There are times when you have to be concerned only with the God who makes the good news possible, who makes change and the very judgement of change good news and a way forward to new and wider life. It is necessary sometimes simply to consider God as the meaning and the end of life.

This is very important in relation to the whole matter of participation, of taking a part now in the living of one's own life. Unless life has a meaning now, to talk about having a meaning "then" is nonsense. Thus we must be now in the presence of God and sometimes may even be able to be reminded of it. Therefore, if we are going to consider the whole range of what is involved in a properly human concern for moral issues in health care or elsewhere, we must also be immersed properly in the material without any thought of the differentia, and we must also be concerned with God without, I would say, any thought of His relevance. It is, I think, the combination of all these three ways of approach which is to do with sitting lightly to identity. We can be involved, say as social workers or as medical persons, in agonizing discussions about what is best for so-and-so in such-and-such situation. But, in fact, we cannot know what is "best", we just cannot. We cannot because of the practical details which are never complete enough, and we cannot because of the transcendent extension of the whole thing. Moreover, if we knew it, we almost certainly would not be able to do it. We need to be free to *discover* what is best together, both "patient" and "treater". We are now coming to see that just as there are no grounds for *imposing* belief on people, so there are no grounds for *imposing* health on people. Indeed, there are no grounds for stopping people dying, if they want to. I have seen some of these pamphlets about the right to live; somebody should write a pamphlet about the right to die, otherwise we shall get inhuman. Of course, every human being who is offered to us is worthy of infinite compassion, but we do not know what is the true and fulfilling direction of this compassion. Therefore, unless we can combine detachment with attachment, we shall not go on properly and humanly with our work of learning to be human and helping others to have the chance of being human.

Further, this has great political importance. We still have not yet got out of the professional hubris, the Western hubris which is not only practised by some Westerners but a lot of other people who have been trained in the West. If we are really going to be involved in a human work towards "the poor" of the world, then we are concerned with the building up of real participation, with enabling people to be themselves as they themselves wish to be and *not* to be as we see them or expect of them. A splendid phrase was used earlier in our discussion about "humble, vulnerable involvement in persons." That is what everything is really about, and to this end we require the practice of detachment as well as attachment.

ii) The Renewal Of The Church.

In holding a dialogue about moral issues in health care, we have found ourselves led into what is in effect a discussion about developing a certain style of life. Now, if we are going to practise this or learn how to practise this, if we are going to carry on with dialogues like this, with working into our systems what we learn, and with trying to share it with other people, and so on, then what we have to do, among other things, is to discover, rediscover, or even reinvent (according to our theology) the church. By "the church" I mean the sustaining community which is chiefly focused on God. Because it is chiefly focused on God, and because it stems from God, I, for my part, do not believe that the church can be reinvented, but I am using this variety of phrases to cover a whole range of approaches to the church. Precisely because the church is chiefly focused on God and stems from God, the orientation of the true church is both Godward and outwards, for God Himself is outgoing as love. Now, unless we are sustained by worship, unless we can learn somehow to pray, unless we can get some building up from looking back at the tradition, unless we can be reenlivened again and again, unless we can face our questions in fellowship, then all I have been trying to point to will remain so much talk.

It is in the church in the sense I am indicating that one can be reassured again and again that, although our identity is often experienced as a problem, it is primarily a gift. That, under God, is the basic thing. Our identity is a gift, we are here, doing things, with possibilities and opportunities before us. The problem is, where do we go from here? It is above all in and through the church, when it is truly discovered, rediscovered or reinvented, that we receive this knowledge through one another and that we are built up through one another.

In order to discover and rediscover the church as we need it, we must be involved in what I would venture to call "do-it-yourself theology" and "mutual pastoralia". I should claim the Bryant-Jenkins dialogue is do-it-yourself theology and, for the two of us trying to do it, it is also mutual pastoralia. I mean that this dialogue is helping us to live in our situations.

Therefore, one of the tasks the CMC has got to be concerned with, arising from its specific concerns which arise out of the overall concern with helping people to health, wholeness, salvation and humanity, is the rediscovery, the renewal of the church. Not so that the church can be a more powerful

institution, but so that people can live in the church with this identity crisis, which is also an identity gift. This is one way of understanding how the Christian Medical Commission is rightly part of the Division of World Mission and Evangelism and rightly part of the World Council of Churches. There should, therefore, be built into the practical concerns of the CMC the development of styles for do-it-yourself theology and for mutual pastoralia. Without this, discussions of moral issues in health care will never be able to go far enough either in reflection or in effect upon action.

CHAPTER VI:

HEALTH CARE AND JUSTICE

by Dr John H. Bryant and Professor David Jenkins

This is the third stage of the Bryant/Jenkins dialogue and was presented at the annual meeting of the Christian Medical Commission of July 1973. It appeared in its entirety (as reproduced here) in the report of that meeting. The final section, *Position Paper on Health Care and Justice,* was also published as CONTACT 16, August 1973.

BRYANT:

Despite the interest and involvement of a wide variety of health-related agencies and institutions — including governments, WHO and UNICEF, foundations, universities, churches and the Christian Medical Commission — in improving health care for the underserved populations of the world, the numbers of people who benefit from modern health care are increasing slowly, if at all. A partial list of reasons for this slowness of change includes: the magnitude of the health problems themselves, limited health care resources, limited capabilities for designing and managing health care programmes, inadequacies in the education and use of health personnel, traditional predominance of curative approaches to health care and a related dependency on major hospitals, lack of commitment of health professionals, educators and political leaders to serving the underserved, and, overall, a serious maldistribution of health care resources.

It is important to know that the problem goes beyond limitations of resources; the resources that are available could be used to reach more people in need with more effective health care. Within most countries, certain parts of the population are favoured with health care: the elite, those who can pay, those who live in the capital and regional cities, and those who live near or can easily reach hospitals and health centres. Other sectors of the population, which amount to 80 or 90 per cent in some countries, receive little or no care. They are often the ones most in need. This picture holds locally as well as nationally. A hospital, government or church-related, may be the predominant or only source of care for a large area, and while it is open to all who come, its effectiveness is in providing treatment for a limited portion of the population. Its impact on the health of the entire population is not as great as it could be if it functioned as a base in developing preventive and promotive as well as treatment programmes that reached out to the surrounding population.

Change towards the direction of reaching more of the underserved will involve changes at the power centres, in the pattern of political decision making, in the attitudes and commitment of the health professionals and administrators in ministries of health, universities and churches, and in the public's sense of what it is entitled to. From these changes could follow a reordering of priorities and reshaping of health care programmes.

The issue is whether or not the needs of large segments of the population should or should not be met, and it brings us to one of the most fundamental questions of society: To what are people entitled? What is the form of that entitlement, and what can be done to see that they receive it?

Health Care and Human Rights

The question of entitlement to health care can be examined first in terms of human rights. Historically, rights have been considered as *positive rights,* which are recognized by positive law and are necessarily enforceable, and *natural rights* or human rights, which are rooted in natural law. Natural rights belong to people simply because they are human. They are not related to particular positions or stations in life but are universal, applying to all people in all situations. Right to life, liberty, fair trial and privacy are examples of natural or human rights.[1]

There is a question as to whether certain economic and social benefits, such as education and health care, should be included among traditional human rights, which have dealt largely with political and civil rights. Some believe that the worldwide effort to establish mechanisms to ensure traditional human rights has been compromised by attempts to incorporate more specific rights. Rights to old age insurance and to holidays with pay are added, sarcastically perhaps, to emphasize the inappropriateness of these attempts.

In the United Nations, the Commission on Human Rights was instructed in 1948 to draft a convention on human rights aimed at transforming nominal rights into positive rights. In the course of extensive discussions, an awareness emerged of the differences between traditional rights of people and social and economic rights. Ultimately, a covenant was approved by the General Assembly that would set up a permanent juridical body called the Human Rights' Committee to receive complaints from any state party to the covenant. Approved in 1966, the covenant has not yet been ratified by an adequate number of member countries.

Going well beyond the United Nations' position, the Council of Europe established in 1950 the European Covenant for the Protection of Human Rights and Fundamental Freedoms, resulting in the European Commission for Human Rights and the European Court of Human Rights, which can receive petitions from individuals as well as states.

Whatever the position of international or regional agencies with respect to human rights, the historic rights of human beings are positive rights in some countries but not in others. Similarly, social and economic rights, such as education and health care, are positive rights in some places but not in others.

In summary, distinctions can be made among positive rights supported by positive law, natural rights or human rights rooted in natural law, and socioeconomic rights. Should health care be considered a human right? Traditional human rights are characterized as being universal in their application to all people, of paramount importance to people's lives, their implementation operationally practical, and their denial a grave affront to human justice.

I am led to argue for health care as a human right. At the same time there is a semantic softness here that suggests we must go beyond the question of whether or not health care is a right. We are troubled by the fact that many people of our world are underserved, and to a large extent unnecessarily underserved. It is the seeming injustice of that that troubles us. Let us turn, therefore, to the matter of health care and justice.

We can ask Prof. Jenkins for his view of health care as a human right against the background of this discussion of natural rights and socioeconomic rights.

Health Care and Justice

Perhaps the most important modern thinker on the question of justice from the Western tradition is John Rawls of Harvard University. His influential volume **A Theory of Justice** opens with the following statements:

> "Justice is the first virtue of social institutions, as truth is of systems of thought. A theory, however elegant and economical, must be rejected or revised if it is untrue; likewise, laws and institutions, no matter how efficient and well-arranged, must be reformed or abolished if they are unjust. Each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override. For this reason justice denies that the loss of freedom for some is made right by a greater good shared by others. Therefore in a just society, the liberties of equal citizenship are taken as settled; the rights secured by justice are not subject to political bargaining or the calculus of social interest."[2]

Rawls goes on to say that these propositions seem to express our intuitive convictions of the primacy of justice, and he proceeds to describe a theory of justice in the light of which these assertions can be interpreted and assessed. He then develops two principles of justice, one having mainly to do with political and civil liberties, the other with the distribution of social and economic goods and burdens. The two are combined in a general conception of justice: that all social primary goods — liberty and opportunity, income and wealth, and the bases of self-respect — are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favoured.[3]

Health care can be related to justice through this Rawlsian concept: *Whatever health services are available should be equally available to all unless and unequal distribution would be to the advantage of the least favoured.*

This application of justice to health care has profound implications for the allocation of resources, the design of health care systems, and the roles of health-related institutions. A full understanding of these implications needs to be worked out. It is necessary not only to appreciate that the principles of justice are relevant to health care but also to develop the application of those principles in ways that are operationally practical in day-to-day decisions about health care.

I am accepting the direct relevance of Rawls' concept of justice to health care simply because it fits my intuitive conviction. We should ask Prof. Jenkins how this concept fits his intuition and also the theological expression he would give to it.

Distributive Justice

The writings of Nicholas Rescher are helpful in moving towards a more detailed understanding of these issues.[4] He examines distributive justice in an historical perspective, beginning with a critique of utilitarianism and proceeding to a concept of distributive justice that is consistent with that of

Rawls. In following his argument and extending it to health care, we can develop a position that is a tentative beginning with respect to health care and justice.

Distributive justice, according to Rescher, embraces the whole economic dimension of social justice, including the question of the proper distribution of goods and services within society. A point of departure for examining the concepts of distributive justice is the historical position of the utilitarians whose principle stated that utility (the good things of life) should be distributed according to the rule: "The greatest good for the greatest number."

The utility formula involves two factors – greatest good and greatest number – but these two can be in conflict with one another, and the utility principle does not help in resolving the conflict. Thus three individuals or communities, A, B and C, receive shares a, b and c of some common good according to Scheme One or Scheme Two:

Individuals or Communities	Share	Scheme 1	Scheme 2
A	a	3	2
B	b	3	2
C	c	3	6
		9	10

Scheme One provides equally for the number of people involved. Scheme Two provides the greater good (a total of 10) divided unequally. The utility principle does not help in deciding among the alternative distributions.

Some utilitarians advocate the greater good, whatever the distribution, which can work to the enrichment of some and the privation of others. Singled-minded pursuance of increases in the Gross National Product as a goal of economic development is an example.

A modification of the utility principle is to establish a *utility floor* below which no one should be pressed. Thus a concept of distributive justice is to minimize the number of persons in a state of genuine deprivation regarding their share in the available pool of utility. This concept would improve the distribution of resources and also serve as a form of catastrophe prevention in the event that inordinately heavy burdens would fall on some individuals or communities.

There are at least two problems with the utility floor. One is that a floor would be meaningless under conditions of extreme scarcity, giving rise to a condition described as splendidly equalized destitution.

A second problem is that a floor still allows for distributive injustices. Some may be pressed to the floor while others enjoy excesses of the good. To counter this problem, Rescher suggests an equity principle, according to which inequities would be restricted to a range on either side of an average. Such an equity principle helps with the problem of meshing the greatest good and the greatest number.

This discussion has proceeded as though each recipient was equally deserving or equally in need. Spencer said, everybody to count for one, nobody for more than one. So it is that the principle of the greatest good for the greatest number rides roughshod over the distinguishing claims of individuals. As Rescher points out, ignoring individual need is characteristic of naïve utilitarianism and unsophisticated welfare economics.

When St Paul said, "Masters, give unto your servants that which is just and equal", he did not mean equal to one another but equal to their deserts.

Thus the greatest good for the greatest number should be modified to take into account the legitimate claims of individuals. This concept is particularly important in the context of justice and health care where "legitimate claims" would be expressed in terms of needs for health care. (See below.)

Other complications affecting the justice of distribution need to be appreciated. (Their relevance to health care will be discussed later.) One problem is that of dividing a good of limited divisibility in an economy of scarcity. In dividing four marbles among five boys, arbitrary choices are involved, but justice requires that each boy have an equal chance of getting the good. This problem appears in the health field in the form of hospitals and other nondivisible health care resources.

Another set of complications relates to the availability of resources. In an economy of dire insufficiency, there is not enough to go around – not enough for a floor and not enough to meet claims proportional to deserts – and justice (in a restricted sense) cannot be done. If the economy is one of mere insufficiency, there may be a floor but not be enough to satisfy everyone's legitimate claims. In an economy of abundance, the floor may be raised progressively, but expectations also rise, and the paradox of an economy of felt insufficiency becomes apparent. The concept of catastrophe prevention is operative but with an altered notion of catastrophe.

Justice is also involved in the way in which a just distribution is arrived at and carried out, particularly when limitations of resources require inequities of distribution. This point has to do with the participation of members of the society in determining what is just and how that justice is implemented.

In summary, distributive justice calls for modification of the utilitarian principle of the greatest good for the greatest number to include:

1. A floor of an accepted minimum.
2. An effective average such that discrepancies of distribution above the floor are not excessive.
3. The legitimate claims of individuals.
4. Recognition of special problems associated with the distribution of indivisible goods, and economies of scarcity and abundance.
5. How the mode of distribution is decided on and carried out.

Principles Of Justice As Related To Health Care

Rawls' principle of justice can be expressed for health care as follows:

> *Whatever health care is available should be equally available to all. Departures from that equality of distribution are permissible only if those worst off are made better off.*

Obviously, there are great discrepancies between this principle and the way health care is provided in most countries. What guidelines can be offered to assist in the development of health services that are more just?

We will begin by stating a series of principles and then proceed to a description of how those principles might be implemented in a health care system with national, regional and local components. Because of the variations in settings and types of health systems, this discussion will be directed towards a particular type of setting: a less developed country, generally representative of Africa and Asia, in which most health care is provided by government with private and voluntary institutions functioning in cooperation with government.

Before proceeding, let the point be made that this is a tentative exploration, an effort to see if principles of justice can be expressed for health care, and to see if those principles can be made operationally practical in a health care situation.

The major principle is adapted from Rawls' as above:

> *Whatever health services are available should be equally available to all. Departures from that equality of distribution are permissible only if those worst off are made better off.*

For clarification it might be well to define "those worst off" in terms of their need for health care based on existing illness or on the risk of becoming ill and their desire or demand for health care. "Are made better off" indicates that justice is not done merely by redistributing resources in favour of those worst off but that a favourable health care outcome would be the goal.

Secondary principles are adapted largely from Rescher's discussion of distributive justice and are consistent with the above major principle.

> *There should be a floor or minimum of health services for all.*

An exception would be conditions of dire insufficiency where a floor would be meaningless. A floor of service should not be construed as an optimum but the least that can be made available to all or nearly all.

> *Resources above the floor should be distributed according to need.* *

One of the most difficult questions to be faced in health care has to do with how to decide whom to serve when resources are inadequate to serve all.[5] The question is usually ignored and care is provided for some, such as those who seek it and those who live in or around urban centres, whereas others receive little or no care, even though they may be in serious need of it. Malnourished children and women at risk to develop complications of pregnancy and childbirth are prime examples. The question applies whether or not there is a floor because their needs may not be met through the health services that constitute the floor.

Justice would be met by using some of the health care resources to meet the special needs of those in greatest need. To do so, however, requires first taking the needs of all into account and then arriving at decisions as to who are in greatest need. From the individual's point of view, justice is done by taking one's needs into account, even though one's needs might not be met. The injustice would lie not in not receiving care but in not having one's need taken into account as decisions were made on who should receive care.

The principle is made operationally practical by assessing the needs of defined populations, setting priorities in terms of health problems and population groups, developing programmes that represent best use of resources in caring for those problems and population groups and, in the course of doing so, reach individuals in greatest need. A survey of a population may reveal (or it may be known from local experience without a survey) that malnutrition and complications of pregnancy and childbirth are major problems. They might be given

---

* There might be no floor, but this principle could still be operative.

priority, but resources might still be inadequate to provide care for all malnourished children and all pregnant women. A simple screening system, using auxiliary health personnel and trained community workers, can search through the population, identifying the most malnourished children and the women most at risk to develop complications of pregnancy and childbirth.* They can then be cared for to the extent that resources are available. The thoroughness of assessment of the population and individual needs will vary, of course, according to resources, from simple to elaborate.

In those instances where health care resources are nondivisible or necessarily uneven, their distribution should be of advantage to the least favoured.

A hospital is a nondivisible resource. The placement of a hospital in a health care system should be to the advantage of the least favoured, a principle that would result in increased hospital construction at the regional, provincial and perhaps district levels rather than in major cities. It is recognized, of course, that all the people of a region or a nation may benefit from the central placement of a facility when it is necessary in terms of an overall network.

In initiating new programmes, such as for environmental control or maternal and child care, the first phases of their distribution would necessarily be uneven, but that distribution should be to the ultimate advantage of the least favoured. The application of this principle would run counter to the practice of outreach programmes from capital cities and hospitals that are planned more for the convenience of the providers than for the needs of the people, many of which do not get beyond demonstration stages.

Application Of Principles Of Justice To A Hypothetical Health Care System

These principles of justice related to health care can apply whatever the level of resources available for health care. Their application to a hypothetical national health system is shown schematically in Figure 1. This formulation is quite primitive and shows little of the complexity that such a health care system would actually have. The formulation is intended to illustrate how these principles of justice can be used in conceptualizing the distribution and function of health care resources in a health care programme or system.

Three levels of health-related resources are shown: extreme scarcity, moderate scarcity and mild scarcity.* The three secondary principles of distributive justice related to health care are included: distribution of resources that are non-divisible or necessarily uneven, a floor of health services for all (or, to be practical, nearly all), and distributing resources above the floor according to need.

At the level of extreme scarcity in a very poor country in the early stages of developing its health services, resources would be inadequate to provide a floor of services for all, except perhaps for immunizations, though even effective immunization of a population depends largely on a basic health service being in place. The country would have a few hospitals, health centres and health care programmes necessarily scattered unevenly. There would be inadequate health-related data and limited resources and capability for surveys of health problems, though, of course, the leading health problems would be known from experience. This is the level at which resources are inadequate for justice to be done, except possibly at a local level where special resources might allow, as in a university or church-related programme. There, the approach described under conditions of moderate scarcity could be undertaken.

At the level of moderate scarcity, in a poor country farther along in developing its health service but still able to reach only part of its population, resources are adequate to make a floor of health services. The floor could include a basic health service in the form of a network of health centres, perhaps one to 50,000 of population, that would make a simple level of primary care** available to all at the health centres, though not all would seek it. The floor might also include some outreach services, such as immunizations and malaria eradication.

Since many needs for health care would not be met by the floor, justice calls for using resources above the floor according to needs. The major health problems would be determined, priorities agreed upon, and searching mechanisms developed to find

---

* Malnutrition in small children can be diagnosed by measurements such as weight for age. Risks for complications of pregnancy and childbirth can be identified by questions such as number of births, previous obstetrical abnormalities, etc.

* From a practical point of view, health care resources are always limited relative to need, even in the most affluent societies.

** Primary care refers to the first contact of patients with health personnel, resulting either in the provision of appropriate care or referral to other health personnel. Primary care can be provided by a general physician or by paramedical and auxiliary personnel. Secondary care refers to care provided by a general specialist, such as a surgeon, obstetrician or paediatrician. Tertiary care is provided by a sub-specialist, such as a cardiologist or a neurosurgeon.

Figure 1

Principles of Justice Related to Health Care Applied to a Hypothetical National Health Care System

Level of Resources ↓ / Principle of Justice →	Nondivisible and Necessarily Uneven Resources Distributed to Advantage of Least Favoured	Floor of Health Services to All (or nearly all)	Resources Above Floor Distributed According to Need
Extreme Scarcity Very poor country early in development of health services	Nondivisible: Hospital(s) Necessarily Uneven: Health Centres Occasional Programmes Nutrition Leprosy, etc.	Immunizations	Resources inadequate to determine needs of population groups and individuals, though this might be done locally, where resources allow, as in church-related, university or special government programmes
Moderate Scarcity Poor country, farther along in development of health services but still able to reach limited proportion of its population	Nondivisible: Central hospital Regional hospital Necessarily Uneven: Provincial and District – hospitals – programmes . nutrition . family planning . environmental control Physicians Nurses Dentists	Basic health care networks: Health centres (1:50,000) providing: – primary medical care – refer to hospitals for secondary and tertiary care – immunizations (Resources inadequate for more extensive services for all)	1. Population survey – simple methods, by sampling – set priorities 2. Search for communities and individuals in greatest need or risk (examples) – malnutrition – overly large and poorly-spaced families – complication of pregnancy and childbirth – tuberculosis 3. Provide care according to availability of resources
Mild Scarcity Substantial resources, well-developed system, resources still inadequate relative to need	Nondivisible: Central hospital Regional hospitals Provincial hospitals Necessarily uneven: Addition of more health centres Pilot projects Physicians Nurses Dentists	Basic health care network organized around health centres (1:25,000) provide: – primary care (referral for secondary and tertiary care) – MCH: immunizations pregnancy & childbirth family planning nutrition education – Environmental control	1. Population survey – method according to resources – set priorities 2. Search for individuals in greatest need or risk not met by floor of basic health services, such as: – tuberculosis – leprosy – parasitic diseases – hypertension – dental disease 3. Provide care as resources allow

particular communities, families and individuals in greatest need or at greatest risk. Malnutrition, gastroenteritis, overly large or poorly-spaced families would be examples. The searching would be followed by the provision of treatment and preventive care to the extent that resources were available.

Nondivisible resources, such as hospitals, would be distributed so as to provide primary care to their immediate communities and secondary and tertiary care on a referral basis for health centres and other hospitals. Some resources would have a necessarily uneven distribution : a new tier of hospitals being added, as at the district or provincial level;

programmes in the early phases of development and distribution, such as nutrition, family planning and environmental health; and health personnel, such as physicians, nurses and dentists, whose distribution is complicated by their personal preferences. A just distribution would favour those populations that were worst off.

In the evolution of a health care system with gradually increasing resources, justice calls for raising the floor of health services to all. That would be reflected in Figure 1 by the movement of resources from the two lateral columns, which represent unequal distributions, to the middle column. The two lateral columns would be continually occupied by new facilities and programmes as new resources and new technology became available for either necessarily uneven distribution or to meet the special needs of particular communities and persons.

The level of mild scarcity describes a country with substantial resources and a well-developed health care system. Still resources are inadequate to meet the needs of all. The floor includes a more developed basic health care network, providing more ready access for all the population to selected services, both in the health centres and out in the communities. Potentially, the entire population would be reached by maternal and child care programmes and some environmental control programmes. Not included in the floor would be programmes to identify and care for communities and individuals afflicted by, or at risk with respect to, health problems that now have priority at this increased level of resources, such as certain parasitic diseases, tuberculosis, leprosy, dental illness, and so forth.

Reflections On Health Care And Justice

The health care system described here is quite like those in much of Africa and Asia. Most of those systems have the goal of covering the entire population, though most also fall short of it. This hypothetical system differs from them mainly in being explicit about having a floor of services for all; using resources above the floor according to needs and having practical means for finding communities and individuals in greatest need; and working continually towards the advantage of the least favoured.

The principle of providing care according to needs, which requires searching through the population for those most in need, is an example of human justice coming together with what is eminently sensible in terms of making the best use of limited resources. It is also necessary if individuals are not to be lost from sight and from health care, often to suffer or die or become disabled unnecessarily. This is exceedingly important, it seems to me, in terms of human dignity and the intrinsic value of individual human beings. Perhaps these are expressions of the intuitive conviction of the importance that justice be done in health care.

In providing health care for populations, our statistical understanding of their needs often requires a departure from a primary, often exclusive, focus on providing care for those who seek it (a departure that is often difficult for health personnel trained to provide care on a one-to-one relationship with individual patients). In the interest of justice, we are led back again to a concern for individuals, not all individuals (though we care about all of them), nor individuals indiscriminately, but individuals who are in particular need and whose needs can be met, at least to some extent.

We can ask Prof. Jenkins to reflect on the importance of pointing limited resources towards those in greatest need and on their value as individuals, whoever they are and whatever they might become.

These principles of justice as related to health care and their application in a health care system are offered as tentative and incomplete formulations. Enough has been presented, however, to establish a basis for expressing the distribution of health care resources in terms of justice, that most existing health care systems are seriously unjust, and that there are operationally practical approaches to developing health care systems and programmes that are consistent with the principles of justice.

It needs to be made unmistakably clear, however, that most of the health care systems with which we work are unjust. Whatever explanation might be put forth for how they got that way, let us not allow the injustices of them to be ignored.

It is no less than brazen of me to point to health care systems around the world and say that they are unjust. That may seem to be directed towards diminishing the efforts of men and women who have devoted and continue to devote themselves to the service of humanity. I do not intend that. But now, at this moment in time, there is a basis for recognizing injustice; and if the basis is sound, it should not be denied. Indeed, to deny the injustice would in itself contribute to injustice. Rather, we should see this as a time to build on a new recognition, to capitalize on the strength of the concept of human justice to build new commitments and new methods for developing more just approaches to health care.

The message to the churches should be felt with particular force. Their commitment to serve the needs and dignity of human beings is central to their commitment to do God's work. We can hope that once the human injustice of the health care systems

of which they are a part and for which they are responsible is clearly seen, and the moral and theological implications of that responsibility appreciated, they will move with courage and creativity into the long and difficult task of building more just systems.

JENKINS:

The Christian Medical Commission, as well as very many others, is concerned with health. The drive of our work has been to discover (or record and work out) the implications of the realization that health implies the wider concepts which we have pointed to by phrases like "Health care and community." But health care and community are notions, are ideas, are practices, are operations and functions, which imply both questions about participation and questions about use of resources. But questions about health care and community, in fact raise, or resources, when looked at in enlarged perspectives abouth health care and community, in fact raise, or actually are, questions of politics. For, both participation and allocation of resources are, in fact and in practice, about power. Who has power to take what decisions about what? Who has power over availability and distribution? When questions like this are followed up, we seem to be faced with what are, in almost the most literal sense, revolutionary implications. As Dr Bryant in effect pointed out at the end of his remarks, you are forced to the conclusion that, as a plain matter of fact, (leaving ideological considerations aside), the health care systems in which we are involved are unjust.

So we are faced with these questions of power, politics and injustice. Therefore, the question comes up, How far should this discovery, this disturbance actually be pushed? We have to operate practically and immediately with regard to health, developing health care schemes, and so on. How far do we go? What practical understandings which are available for guiding present or immediately future operations can we have about things like human expectations? When are people entitled to feel disappointed, deprived, badly done by, worse off? What do we really mean, or what would it be feasible to mean, by "justice"? Possibly, therefore, this attempt to link health care and human rights is picked up as being the way of focusing on, and a way of getting a grip on, our situation which has been undermined because of the steps which we have been led through in linking health, community and justice. This also ties up with our main theme for tomorrow, namely, health care and justice. How do you find a standing ground from which you can approach this? Perhaps the notion of health care as a human right, associated with concepts of social justice, is a possible way of handling this.

If my diagnosis is at all correct, then certain problems arise in my mind. For example, one reason for having a possible way of handling something is in order to cut it down to size and put it back into a box where it can be controlled or forgotten. Again, human rights is a notion which has had quite a respectable history in Western philosophy, political theory, and so on. Hence we might feel at home in this and not so disturbed. Now, I do not know whether this is correct at all. This is simply trying to find a way into the discussion which Dr Bryant has raised here.

The Aims Of Theological Reflection On Health Care

But, I am supposed to be coming to theological reflection. What then is theological reflection for? There seem to me to be at least three things which it is for. The first is to do with the problem of the relationship between ourselves as Christian Medical Commission and our constituency. Why "Christian"? How do we show that what we hold to be important things, which have to be got on with, are important also to our constituency? To pick up Dr Bryant's last point, "How would you relate this concern of ours to a message to the churches"? This is not just a selling operation or an attempt at self-justification. If we ask ourselves how we justify our concerns to the constituency, that is to say to the Christian churches, we are also going into the question of checking up on ourselves as Christians. It is, I think, a very important and necessary operation to check up on this because of what I may call "the bandwagon syndrome". The bandwagon syndrome is the tendency of organizations, especially when they are having a difficult time, to jump on to the latest bandwagon, in the hope that they will thereby justify their existence. Now, there is no doubt that everyone is getting very worked up about social justice, and it is generally considered a good thing to be in favour of social justice. But it is necessary to ask what is really involved here. What is a good thing, when it is a good thing, to be worked up about? I know this sounds funny but, as a matter of fact, it is very important. All sorts of people claim to go around doing good to people, having revolutions to free people, maintaining the status quo to protect people. But what people claim and what they do are often very different. So there is a strong case for theological checking up.

But there is a much more positive reason for theological checking. If it is at all true that there is a Christian Gospel, that there is a true God, like the one portrayed in the Bible who cares for us to the point where He totally gives Himself away, then the relationship between the health of people and the salvation of God should be a very dynamic one. There should be many possibilities of perceiving priorities and creative choices in the complicated field we are working in. We need the clues which can come from the insights of faith. (It might be noted in passing, and for possible further reflection if we do extend this dialogue further, that our Christian theological and faithful clues might call in question

the whole notion of "having ground to stand on", which I mentioned at the beginning of my reflections. Perhaps we have to find our way as Christians and human beings in situations of disturbance and confusion by taking the risk of losing ourselves and the "ground" on which we try to base our identity and our understanding. This, however, is a hint which I simply register in case it ought to be followed up.)

The third reason for theologizing is to see what hopes and resources arise from our Christian faith, which help us to maintain a lively pursuit of the things which are glimpsed as valuable, just and humanizing. We all know that to recognize rights is not to achieve the granting of those rights. We know, too, that many human obstacles, from within one's self and from others, stand in the way of health and justice and community. What resources and possibilities do we really have available to us? So, to attempt theological reflection is to attempt to check up on our concerns by relating them to the Christian community, the Christian tradition and the Christian Gospel; it is to look for clues about priorities and creative choices, and it is to seek for help and hopes and resources which are related realistically to the struggles and opportunities we have to face.

Limitations Of The Concept Of Human Rights

If then I combine my initial questioning about the reasons for relating health care and human rights with the understanding of theological reflection which I have just outlined, the following considerations occur to me at the moment.

First of all, it seems to me that there are some considerable difficulties about the whole notion of *human rights.* It seems to be very difficult to "locate" human rights. Who has a right from whom, for what, why? There seems to be an assumption that the universe has a certain nature which may not exist. For example, "rights" has a certain implication of fitting in, it seems to me; and perhaps nothing fits into anything. Or alternatively, it may only have a sense in the positive sense which Dr Bryant mentioned, which means when you have set up legislative bodies or other sources of rights. You then have problems about where the sources of rights can themselves derive their rights and authority. So the notion behind the notion of rights does not seem to me to be necessarily clear or necessarily satisfactory.

This is extended into a second point, which I think is more important or may perhaps just be a reinforcement. It seems to me quite clear that the usual talk about human rights is a very Western one. This applies also to Dr Bryant's discussion about justice. The material on the whole arises out of some view about government and the individual which is associated with John Locke, in England, and corresponding figures elsewhere. For instance, rights mean protection of the individual against government and against arbitrary institutions. Such a concept cannot really cope, for example, with any approach to the universe which says that the whole point about government is to express the people's needs against oppressors. So the notion of human rights on the whole, and up to the present, tends to be related to a list of certain irreducible things, which irreducible things are largely thought of in the way they were thought of somewhere about the 17th century, somewhere round about France and Britain. This is rather an oversimplification, but Dr Bryant did use the phrase "historical and traditional human rights", and this raises questions about which traditions and which human beings. Thus the universalization of the notion seems to me to be exceedingly difficult.

Further, it does not seem to me that the notion of human rights is biblical at all. I doubt if the Bible has any interest in human rights whatsoever. But I think that the Bible is immensely concerned about human possibilities, about divine activities, and about human response to divine activities.

The biblical pictures, patterns and processes which are, I believe, very relevant to the area which is often labelled human rights are those which are concerned with what I may call the divine attack, or human attack under divine inspiration, on the obstacles to becoming human. The Bible seems much more concerned with attacking exploitations, attacking oppressions, attacking inequalities, attacking deprivation than with laying down rights. Indeed, in one sense, nobody has any rights anyway because they are totally dependent on everyone else and on God. The notion of an isolated entity with rights is one of the most inhuman that ever existed. Moreover, the human possibilities visualized in the Bible are related to the infinitudes of God and, consequently, to suggest a list of "rights" may well be gravely limiting and restrictive. This is not to say that there may not be room for intermediate, functional and operative concepts here. Indeed, I am inclined to think that any notion of rights must be strictly secondary, derivative and functional.

An illustration of the relative and derivative nature of "human rights" might be drawn from an area which has often been of particularly ecclesiastical concern. Consider the relationship between being human and having the right to freedom of religion. Under some circumstances people need to be set free for religion, religious practice, and so on. But at other times, there is need for a right to be free from religion. The whole matter is highly relative. I would also add, as a suggestion which I have not at all thought through, that the need to talk about rights or claim rights may, in itself, reflect a sinful and dehumanizing situation. Talk about rights is perhaps

generated by oppression and failures in communal relationships. Therefore, the proper focus of concern is removing obstacles and attacking exploitations and oppressions. Theologically speaking, one might do best to understand the phrase "health care as a human right" as a disturbing notion. It can be used both to focus a whole series of disturbances and to push them forward so that it is even more disturbing. Its proper use is to point to obstacles rather than to talk definitively about justice, to direct attention to manifest injustices, and to point to situations which are in fact deprivation and, therefore, unjust exploitation. The motive for this is not, in fact, justice, but love. Justice and rights are secondary. They are vital things but secondary to a concern of love. It may well be, therefore, that Dr Bryant's attempt to discuss the problems which concern him in relation to a measured discussion of rights and of concepts of justice fails to do justice to the very disturbing implications of what our work in the Christian Medical Commission is forcing us to discover.

The Need To Be Taken Into Account

A further point which may be relevant here is connected with Dr Bryant's discussion of distribution of scarce resources. He suggests that "Justice would be met by using some of the health care resources to meet the special needs of those in greatest need." I think that this is a helpful notion and well worth following up. However, as part of my role as "theological disturber", I should also like to raise the question of "what people *really* need." I wonder if taking people's "special needs" into account is as penetrating and disturbing with regard to our understanding of justice as facing up to the fact that, in any area of distribution and power, what people really need (as human beings) and what they are basically entitled to (as in the image of God) is to be taken into account as people. A concern about everyone being taken into account does not mean that everyone has a right to a list of things (although you may need the concept of a "floor" to indicate certain immediate minima to be aimed at), but simply what it says — namely, that everyone has to be taken into account. This is a very basic assertion from any Christian point of view. (A point of view which here can coincide with others, but we are talking about Christian theology.) From a Christian viewpoint, being human is in itself, to use a very old-fashioned phrase, an "ontological" status. God has given us the opportunity of being human; we are created to be human and, therefore, we have an inalienable right to be so. To take everyone into account is, therefore, related to the "essence" of being human. So, one is concerned with injustice, deprivation and counting; not with rights and justice, as if they were positive notions. This, I think, would be my way into the theological justification of Christian concern. The notion of health care as a human right is best taken as a disturbing notion and not as a defining notion. This would fit in, it seems to me, with one of the basic pictures of God in the Old Testament, which is one of God as the Disturber. Every time He comes across a situation of imbalance, deprivation, injustice, He is prepared to attack it, even if it means destroying Jerusalem.

Theologically speaking, I can see a cautious justification for the notion of health care as a human right, if it is placed in a wider context and seen as a provocation to disturb present practices in the direction of more humanness. More positively, however, we may ask the question about what priorities and creative choices might arise here. I think we already have one clue in this matter of *counting.* In the working out of health care schemes and in the adjustment of schemes to more long-term and more overall aims, it remains always important, humanly speaking, that the people involved should have the chance to count, to play a part of their own. It is more important that you should count rather than that you should get this or that. That sounds banal when put this way, but it would make a great deal of difference to the way schemes are run. What is more important is how you count rather than what you get. Justice, for instance, might be best understood as to do with who is making decisions. Indeed, the very notion of distributive justice is possibly a very dangerous notion, although it can be made into good sense. I suspect that the notion of distributive justice is a possible operative notion at a very minimal level, but is basically sub-Christian. Justice has much more to do with making decisions and with such things as freedom. It could be that the type of discussion which Dr Bryant is promoting would direct us to administrative decisions about sharing out scarce resources rather than human decisions about freedom to participate in these decisions and this sharing.

Here I would like to put in a footnote for consideration at some time. I think that the notion of freedom with regard to justice and health care and distribution and all sorts of things has got to take into account the notion of sacrifice. Freedom in any sort of Christian understanding must have room for reckoning with sacrifice. But free sacrifice is not something which is exacted but something which is offered. Therefore, no notion of sacrifice must be made use of to justify any retention of injustice. Nonetheless, something more positive than distributive justice is needed to take account of the roles of freedom, relationships and sacrifice in being human. Sometimes the picture of a just health care system seems to imply that all would be well if everybody was getting the pills they need, the psychiatric advice they need, and so forth. As a matter of fact (I do not know whether I may say this), I have a suspicion that much would then be wrong. It certainly would not be all right. However, this must not be taken to justify deprivation, maldistribution, injustice, and so on. I have no time

to follow up this idea, but I feel we need to follow up the hint that how you count is more important than what you get. Justice is to do with who is making decisions and with freedom, and there must be room for sacrifice. (Demands for sacrifice, however, do not come well from the lips of people asking sacrifice of other people and not offering it themselves.)

The Need To Be In Relationship

A second hint with regard to priorities and creative choices may arise as follows. If the claim that health care is a human right is really meant to be a disturbing question about obstacles, then what are real obstacles? That is to say, what are the obstacles to being, to becoming more human – which is not necessarily the same thing as obstacles to being healthy, as "healthy" is sometimes narrowly defined. I would suggest that, theologically speaking, the real and basic obstacles are obstacles which prevent or pervert human relationships. One of the most basic notions of what it is to be human is that of being in relationship. Theologically, this is related to the image of God. In much Christian tradition, this understanding of the human being as in the image of God has been understood far too individualistically or as being too much concerned with reason. But any truly Christian understanding of the "image of God" has to be controlled by the Christian understanding of God as Trinity, which is essentially a relational understanding. Therefore, somehow or other, in working out any health scheme, this matter of relationships has to be given a very high priority.

For example, is it not better to live for a short while in relationships than either not to have lived at all or simply to have your life prolonged in isolation? Relationships and the possibilities of loving are the clue to living and being human rather than the mere existence of, or prolongation of life in the animal and vegetative sense. We need to discover how to make this clue operational in relation to health care provisions and institutions. Do we, for instance, enable human living, or do we simply prolong inhuman life? Do our institutions serve people in their relationships and enable them to maintain and enjoy those? And what are our criteria of efficiency – the mere eradication of disease or the widening of community living and sharing (perhaps with the diseases still around)?

The Need To Contribute And Take Responsibility

A third clue about priorities and creative choices develops further from this notion of the image of God and is to with promotion of responsibility. The relational picture of men and women is also a creative picture of men and women, and to count involves contributing. This is where you could, I suppose, reintroduce the notion of rights because rights do imply also responsibilities. But I personally remain unhappy with the notions of duty, right and responsibility. I think that mutuality and love have to be worked out more in relational notions than in notions of rights and duties. Rights and duties are subordinate to mutuality and responsibility. And counting involves the possibility of contributing and taking responsibility.

Here, I should like to draw attention to a possible way in which an understanding of mutuality and responsibility puts a check on the notion of rights. There seems to be some tendency to claim that people have a right to more and more with regard to refinements of health care and sophistication of medical services. But there must, surely, be strict limitations here. For instance, it seems to me there can be no question from a human and Christian point of view of people having rights to kidney machines or heart transplants. And I think it very likely that a whole lot of other things that go with Western health schemes are not rights but are even abuses and extravagances. We need to develop and clarify here. We will never be able to deal with unlimited rising expectations; and the more expectations arise, the more people become convinced that they have been deprived. We need to strive to build up and respond to expectations which are related to human relationships and mutual responsibility rather than to mere extension and consumption of services. Discernment will be difficult here, and we have to be careful not to be indifferent to gross imbalances in what is available to people. But we have, nonetheless, to follow up the clue that counting involves contributing and that contributing and being responsible involves not *over*using. Our task will be so difficult here because the churches have become almost hopelessly overidentified with the expectations and cultures of the countries in which they are strongest. Distinctively Christian witness to a restraint and discipline which is related to responsibility and mutuality is therefore not easy. The real repentance that is required here is going to be one of our greatest problems, if we are truly going to work as a Christian Medical Commission in relation to our churches and societies. Priorities and creative choices are then to do with setting free for mutuality, relationship, responsibility and contributing.

Hopes And Resources

But what hopes and resources are there for working realistically towards this sort of thing? Both some of Dr Bryant's pictures of the ideal possibilities and some of mine are clearly, in one sense, quite impossible in any systematic way. People and institutions are not like that. But I think there are several considerations that help us to work nonetheless. The first one is what I would like to call – from the Christian theological point of view – **the hopefulness of solidarity in sin.** It is perfectly true that all the situations and structures in which we are involved

include situations of injustice and tend to promote and produce injustice. But the Christian faith and the Gospel recognize that we are *all* involved in this and declares that that is the human situation which is recognized by God, in which He works, and from which He goes on to creative things. We are set free, therefore, to recognize fully the injustice, without being inhibited by our share in it or crippled by its so far continuing existence. There is no need to say, "Oh, it is inevitable, so we won't even recognize the injustice."

We can be supported in facing the tension between recognizing injustice and being unable to alter this until some opportunity for action does arise.

Further, once we understand that "solidarity in sin" is a true description of the whole human condition, and that by the grace of God we have opportunities of responding creatively and humanly nonetheless, we can also see that being involved in injustice does not totally condemn people or make one set of people decisively "worse" than another. Therefore, for example, health administrators and church administrators do not have to defend themselves as being righteous in what they do in order to retain their status or hopes as human beings. If we constantly have to maintain that we are righteous, because this is *the* right way to produce health, this is *the* right way to be a Christian, and what is more, we are doing rather well at it, then there is no possibility of the sort of flexibility and repentance which changes unjust and inhuman situations. So a living understanding of the hopefulness of solidarity in sin seems to be of fundamental importance.

It also seems to be of importance because it should set us free from one of the most debilitating practices of the present moment, and that is the habit of finding scapegoats. Each ideology has its own set of scapegoats. They are all oversimplifications. It is just not true that the people who are against law and order are responsible for all the ills of the world. Nor is it true that it is this or that social system which is responsible for *all* the ills of the world. It is not true that all the ills of the Third World are the fault of the First World. Or if it is true, it is because the world is like that and the First World is caught up in it as well as the Third World. This is not to deny the need for a common dialogue, where Third World accuses First World and First World has to give an answer, and so on. But it is not true to make "them" the scapegoats for everything. Such views distort judgement, paralyse action and prevent the hopeful taking up of responsibility and response.

This understanding of our human solidarity in sin is also, I believe, closely related to what is perhaps the most distinctive and discomforting command of Jesus Christ, His command to love our enemies. We may have to fight for our rights or to fight for the rights of others. But we are not, as followers of Jesus Christ, to hate our oppressors and enemies. We and they together share solidarity in sin and the hope of a humanness rescued and fulfilled by redemption. Here is a quite fundamental challenge to avail ourselves of a resource, the suffering love of God, which radically alters our approach to human struggles for health, freedom, fulfilment. It may be that power is all that counts in the world and that when men use power to exploit or deprive others, hate of them must be our guide. If this is so, then Jesus is not the Christ, and we have neither a reason nor an excuse for a Christian Medical Commission, the Christian Church or the Christian Gospel.

A second area related to hopes and resources which we may draw from our Christian faith may be indicated by the phrase **"The non-utopian nature of impossible hopes."** When we express hopes about making the world a better place, developing more just health systems, and so on, people come along and say, "But this is utopian," by which they mean it will never come off, and therefore there is no point in moving in the direction of such an impossible hope. Christian faith and theology, however, encourage us to work realistically towards these impossible hopes, without being romantic about the difficulites or utopian about the possibilities. The final hopes and fulfilments of the Kingdom of God, which lie beyond history, can be related now to possibilities and improvements for which we strive in history. It is perfectly proper to hope and work for steady improvement in dealing with injustices, deprivations, and so on. And this is exactly what we have to do. But we must not retreat into utopia and suppose that our efforts will produce definitive solutions. Nor must we be driven into cynicism or indifference by occasions when our efforts fail or we are helpless. It is a resource of Christian faith to keep the truly humanizing but impossible hopes alive and constantly to renew action upon them.

This brings me to a third indication of resources stemming from faith in relation to action for health and for justice. We are able to understand that in these practical ways of holding, renewing and acting on impossible hopes, we are dealing with **the possibilities of the infinite in the finite.** These are actually experienced by breaking through one set of finite limitations to another finite situation, not by some sort of breaking through to some ideal situation where everybody has become perfect and all difficulties are forever solved. The breakthrough in any set of finite limitations is simply to get from one limited situation to another set of finite limitations. But the experience of transcendence in the midst is to find that these limitations can be broken through to another set and to another set and to another, and that we are not compelled to settle down with one unsatisfactory set of limitations. Thus we experience the possibilities of the transcendence of God in the midst of our

limitations and realize the ultimate possibilities of our impossible hopes.

To summarize the unsatisfactory incoherence of this response of mine, I would say that I believe the understanding of health care as a human right might best be developed as a disturbing notion, related to attacking obstacles, promoting mutuality and responsibility, and recognizing limitations which are then to be transcended. Further, it may be that one could use the notion along the lines which Dr Bryant is indicating to give urgency: here are actual examples of where the situation is unjust and obviously must be dealt with. It could also be used to give specificity: there is a direction to move in and an immediate objective to aim at. But we need other resources to give hope about relating a constant fight against injustice to limited expectations, limited entitlements and limited resources. We have also to investigate carefully the limitations of the whole notion of rights and of justice, if we are seeking to be responsive to the health, wholeness and salvation of men as they are pointed to by Christian faith and hope. This will be needed also if we are, sympathetically and beyond the limitations of our particular perspectives, to take our part in the real agonies and excitements of the human struggles for justice.

BIBLIOGRAPHY

1. Ranston, Maurice. *What Are Human Rights?* The Bodley Head Ltd., London, 1973
2. Rawls, John. *A Theory of Justice.* Harvard University Press, Cambridge, 1971, pp. 3-4
3. Ibid, p. 303
4. Rescher, Nicholas. *Distributive Justice.* Bobbs-Merrill, New York, 1966
5. Bryant, John and Jenkins, David. "Moral Issues and Health Care". *CONTACT* No. 4, 1971, Christian Medical Commission, World Council of Churches, Geneva

POSITION PAPER ON HEALTH CARE AND JUSTICE

In order to present a synthesis of the main concerns expressed at its July 1973 annual meeting, members of the Christian Medical Commission, during the meeting, drafted, reviewed and accepted in its final form the paper which follows. The paper appeared in the report of the meeting and was also published as CONTACT 16, August 1973.

When the Christian Medical Commission was formed in 1968, its first major activity was to evaluate the existing patterns of relationship between church medical institutions and the people they served. We are deeply conscious of the tremendous dedication and selfless service that have made church-related hospitals unique symbols of the proclamation of Christian love in action. Continuing contributions have been made in changing whole systems of service, providing pioneering approaches to new geographical areas, opening new educational perspectives, and in all of this in demonstrating a high quality of concern. Problems have now arisen which require new adjustments to changing conditions, without derogating in any way the contributions of the past.

1. A SYSTEM WHICH IS INEFFECTIVE, INEFFICIENT AND UNJUST

One sign of trouble has been our inability to keep up with the progressive effort to match in the overseas setting the qualitative improvements in hospital care which have characterized the scientific surge in world medicine. This has required a rapidly escalating investment in both facilities and personnel so that increasingly specialized physicians can work with more elaborate and expensive equipment. Hospitals are doing more and more for the same limited number of patients.

The comments which follow are directed to those in all parts of the world who share our concern. The Commission's studies of the past five years have shown that the traditional hospital-based approaches have been both ineffective and inefficient.

Our approach has been ineffective in meeting the total needs of populations for both physical and spiritual healing. Community surveys show that we reach only a fraction of the people in a hospital's orbit. It is no longer enough to say that our responsibility is only to provide a facility and then it is up to the people to come. Rather, the service personnel must take more initiative. The fact that the most intolerable health conditions are perpetuated immediately around our hospitals is scarcely a Christian witness. Deplorable health conditions cannot be casually blamed on prevailing social and political conditions. When we did not have effectual measures for health improvement, it may have been justifiable only to practise curative medicine. Now that we have increasingly potent tools for both curative and preventive services, we must apply a whole new standard of priorities, based on careful analysis of those approaches which are most effective in improving health. Almost all hospitals are doing something about prevention, but no effort has been made to use a cost/effectiveness approach in getting a more appropriate balance between curative and preventive activities. A common response is that we will get around to prevention after we have taken care of immediate medical needs and emergencies. The seen sick patient before us has an emotional imperative that draws us away from such activities as caring for the unseen thousands of children around us who need better nutrition. But a concern for effectiveness will require a better balance of preventive activities.

The hospital-focused health care system is also inefficient. A clinical condition that requires massive investments — especially in the most precious commodity of personnel time — could often have been prevented at a fraction of the cost. This is especially true of the health problems that crowd the wards in poor communities. Our inefficiency is also evident in the way we use time within the hospital. Because of archaic medical prejudices about clinical care being the doctor's preserve, we do not turn routine treatment over to auxiliary personnel, although it has been abundantly demonstrated that they can care for 90 per cent of illnesses as effectively as physicians. Patients must invest inordinate amounts of wasted time in waiting while

nothing is done – both as inpatients and outpatients – while the harassed doctor is trying to get through a phenomenal daily burden, most of which could be handled just as well by others. The fact is that elaborate hospital facilities are designed more to serve the professional convenience of overly busy physicians than the well-being of patients. Most seriously, the people are not given the education that would permit them to take care of their own health problems. They are also not given the compassionate listening time needed to unburden their psychological problems and fears.

The Christian Medical Commission has shared with others increasing attempts to publicize these areas of concern. The generally favourable response has been most encouraging. Our further deliberations have now brought us to an additional insight, which we are planning to explore in more depth. We communicate our thinking at this time with the hope that we will get the widest possible participation in our exploration.

For Christians the most serious indictment of a primarily hospital-oriented health care system is that it is not only ineffective and inefficient but that it is also unjust. In fact, it is unjust partly because it is ineffective and inefficient. The technical inefficiency and ineffectiveness we must be sensitive to professionally, but those with Christian concern must be especially sensitive to the injustices of the health system.

2. EQUITABLE DISTRIBUTION OF HEALTH CARE

The definition of injustice here starts with the conviction that basic morality requires equitable distribution. The greatest moral dilemma of medical care is to find the least unjust way to allocate scarce resources. We cannot just open facilities and wait for the centripetal and spontaneous inflow of patients. Our concern must be centrifugal in reaching out to all those in need. Accessibility has three sorts of constraints:

- geographical
  – this means that we must decentralize services;

- sociocultural
  – this requires the removal of real or imagined barriers, especially those that are culturally misinterpreted because the impersonal environment of the hospital tends to frighten the ordinary patient; we must also be prepared to help patients understand the root causes of their disease so as to promote prevention; and to help them adjust to questions such as, "Why did this disease happen to me? ";

- economic
  – here we need innovative ways of avoiding the dehumanizing aspects both of expensive private care and of free treatment through providing a mix of financial arrangements for care that is inexpensive while still being good.

The primary requirement then is that there be no discrimination in the way we assume responsibility for total populations around our institutions. This does not imply forcing services on anyone but rather seeing that their needs are recognized and taken into account, and then reaching out to make services available to everyone in the area. Two steps are involved. First, instead of spending all our precious resources on those who come spontaneously, we must work out new ways of defining and providing a basic minimum of services for all. The definition of this basic minimum must be locally derived and strictly limited to ensure coverage. The second part of providing equitable distribution is to set and follow priorities in care. The purpose is to focus on the measures that will do the most for particularly vulnerable groups. This exercise must combine technical understanding with community participation in planning. A major result is that people are helped to solve their own problems.

3. HEALTH CARE RELATED TO THE TOTAL DEVELOPMENT OF THE PERSON

Another pattern of differential deprivation of care is built into the institutional structure of the large modern hospital. Traditional village communities provided multiple mechanisms for social and psychological support for the sick and their families. Modern institutional organization becomes depersonalized, partly because size demands routines and these tend to be dehumanizing. As Christians we can try to compensate by being loving. However, the institutional environment itself often discriminates against the families most in need of support. The provision of health care, particularly in a prestigious hospital, may combine technical excellence with procedures which are destructive of family and social relationships. Ill health in itself places great strains on personal relationships, and the way that problems are handled can be healing in strengthening bonds of caring, or grossly disruptive in callous unconcern for subtle relationships which form the fabric of life.

An important element in the effort to reduce injustice through better health care is to relate health deliberately to the total development of the whole person. Attention must be given to the needs of individuals, families and communities. This requires real collaboration of health workers with those working in the economic and political sectors of community life. It involves especially an

awareness and willingness to do something about such problems as environment, malnutrition and the balance between population growth and development. An exciting possibility is to learn whether a simple, auxiliary-based programme of integrated health and family planning can be an entering wedge in the process of development, both through changing personal attitudes and expectations about the future and also by providing a community-based channel through which felt needs can be expressed.

We speak here mainly of discrimination in the distribution of services available to the communities surrounding hospitals. The same principles apply with even greater force in the planning of regional and national health services.

A truly community-based approach in health care offers a whole new range of involvement and potential renewal for the church. Showing love in action through healing can be a corporate service activity of Christians. With professional guidance, many community activities can be best done by simply trained auxiliaries and volunteers. But church involvement must not be exclusive, it must be inclusive of all who want to serve.

In summary, injustices arise because of:

1. Inequitable distribution of scarce resources. This requires a basic minimum of services for all and priority arrangements to provide special services for vulnerable groups.
2. Communities and individuals do not have opportunities to participate in health care decisions, especially as they relate to total development.
3. The health care system does not promote the wholeness of individual, family and community life through its tendency to depersonalize individual care and disrupt interpersonal relationships, with those who suffer most often being those most in need.

4. CHALLENGES

This leads us to present three challenges to policy makers and funding agencies, to health workers and educators, and to all who share our concern. We reiterate that these challenges represent a new recognition that we hope to explore with many. The Commission commits itself to respond to these challenges and to the further insights that will come out of continuing efforts to improve our understanding and perception.

1. We share in a call to openness, to new vision and insight and a daring readiness to explore complex relationships at the interface between science and human values.
2. The challenge to individuals is that in our daily working setting and relationships we must make our part of the action more just in allocating more equitably those resources we control. But we have to start where we are and use what we have as we move incrementally to innovation.
3. The corporate challenge is that we review critically the justness of the health system as a whole. This does not mean condemning or discarding the means and understanding that have contributed so much in the past. We can now build on the past with our new insights, just as those in the future will build more just systems as today's justice becomes tomorrow's injustice. We justify this call in the belief that there is no force so aggressive yet so healing as love.

MENTAL HEALTH, CHRISTIAN MEDICAL MISSION AND THE FUTURE CONCEPT OF COMPREHENSIVE HEALTH CARE

by Dr R. A. Lambourne

This is the last paper Dr Lambourne wrote before his untimely death in April of 1972. It was first printed as CONTACT 9, June 1972.

Very little has been done by medical missions for the care of persons suffering from psychotic or neurotic illness compared with their record in other fields of healing. Perhaps more should be done. If so, it would make an interesting preparatory research to survey the possible reasons for this situation. Was it a feeling that physical diseases should always have priority? Was it an appreciation that psychiatric care in a foreign culture is especially difficult? Was it a feeling that nothing worthwhile (i.e. cure) could be done with mental illness? Was it some sharp difference between the personality that leads a person into psychiatry and the personality that leads a person into medical mission? Or was it quite other reasons? A careful look at the history of this matter in the last fifty years is surely essential if and when an expansion of medical missionary work in this field is considered. We cannot do this here and now.

A case for such an expansion will not be hard to make. An earlier general presupposition that "primitive" societies do not suffer from mental illness has been replaced by a general presupposition that psychosis is widespread in all cultures and that unhealthy behaviour of a neurotic kind is equally prevalence of alcoholism and other addictions in all though it may take different forms. The widespread prevalence of alchoholism and other addictions in all cultures and the dramatic rise in suicide and attempted suicide in many fast developing countries is a case in point. In the face of large-scale suffering of this kind, the case for an expansion of medical mission in this area of sickness does not require lengthy elaboration.

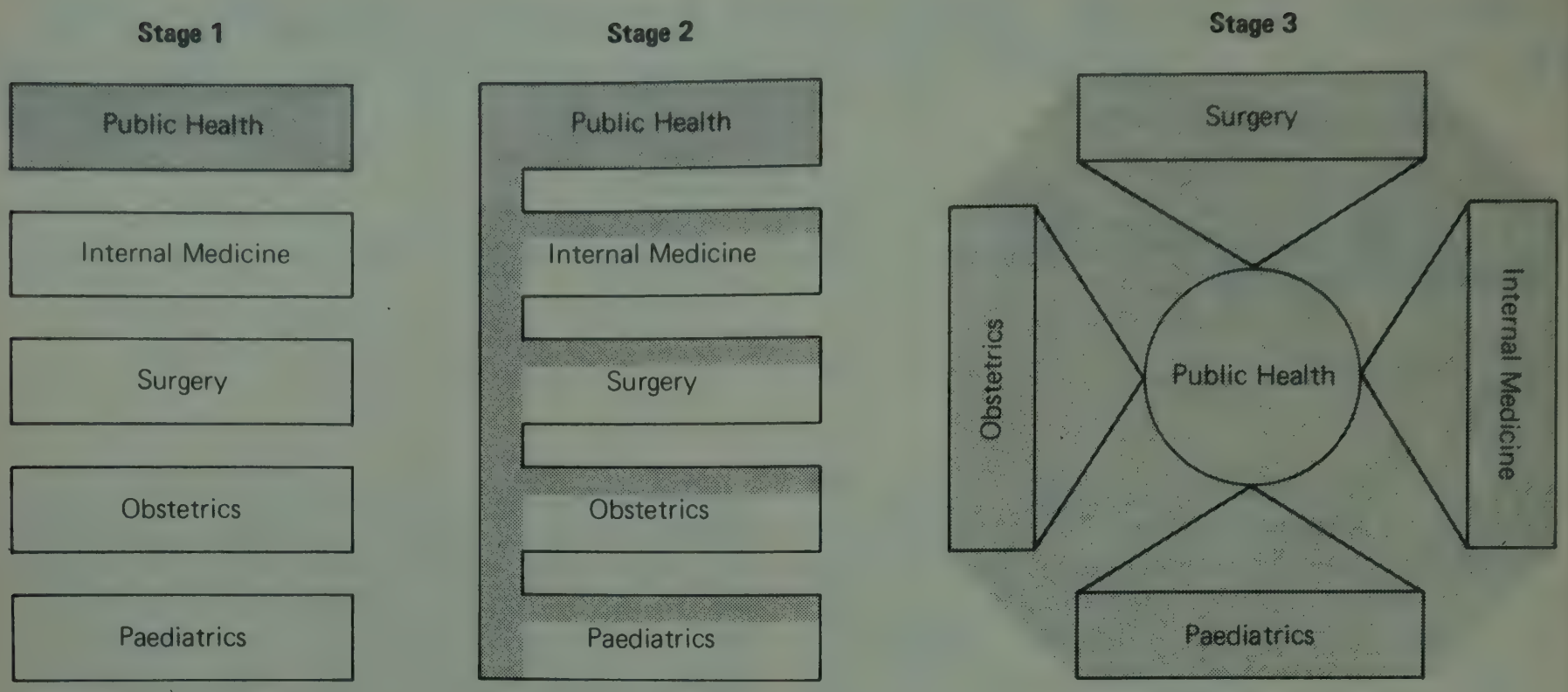
However, before we respond, as I hope we will, to this appeal, we should reflect upon the subtler implications of the projects in psychiatry and mental health which we may adopt. Such reflection is necessary, for as we have learned to our cost in the last decade, it is often just the taken-for-granted language and methods of medicine which conceal unrecognized assumptions which have the most far-reaching effects. We now recognize that every system of medicine and of medical care has implicit within it a philosophy of personal and political behaviour, and it is not possible to be a missionary for one without being a missionary for the other. This is true when the medicine is concerned with those illnesses called physical. How much more aware then we must be of our responsibility when we move as missionaries into the field of psychiatry and mental health in which questions of the nature of true speech and correct social behaviour are so obviously interwoven with the designation of mental illness and its approved treatment. The inevitable *political* ingredient in medical services, previously unrecognized, has become explicit in the last decades as public health has ceased to be only a specialty and become also the originator of a new concept of health. Thus medical mission, always implicitly political, can now be seen to be explicitly *political* mission. The succeeding argument in this paper will be that the *personal* philosophy (i.e. suppositions about the nature of a whole or healthy person) inevitably, though unconsciously, an ingredient in medical services will become explicit in the next decades as psychiatry ceases to be only a specialty and becomes also the originator of new concepts of health. Medical mission, always implicitly commending one view of the personal, will then be seen as explicitly *"personal"* mission.

We will now pursue this analogy between the influence of public health and the influence of psychiatry on the dominant concepts and practices of medicine. Thirty years ago, (see Diagram 1A, Stage 1) public health was a small special subject in the medical curriculum, a specialty amongst others, and having little influence on the main thinking and practice of medical care.

Fifteen years ago (Stage 2) public health approaches were to be found within each specialty but without this changing the specialties' central concepts and practices. Epidemiology still primarily referred to traditional epidemic diseases of an infectious or contagious nature.

Diagram 1A (Compare 2A)

Influence of Public Health on Dominant Concepts and Practices of Medicine



Public health is a separate specialty amongst specialties. Unlike "pure" medicine, it is undeniably involved in politics and therefore suspect.

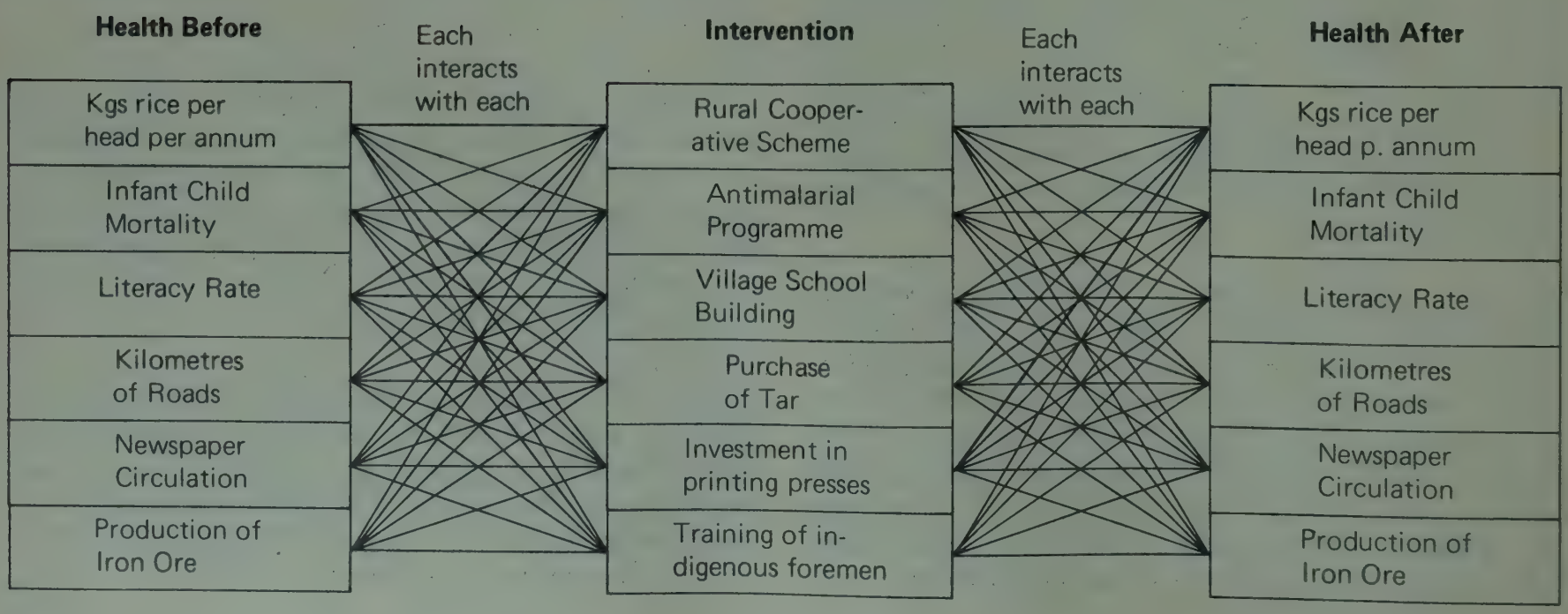
Public health changes some practices in each specialty. But epidemic diseases remain a special class of diseases, and each specialty is judged by its own results.

Public health changes the concept of a disease. Each disease seen now as an illustration of epidemiology. Medicine now seen as comprehensive health care. The political nature of medicine is becoming explicit (see diagrams below).

Shading represents influence of public health concepts.

Diagram 1B (Compare 2B)

The Interaction Between Programmes Expressing the Public Health Influence



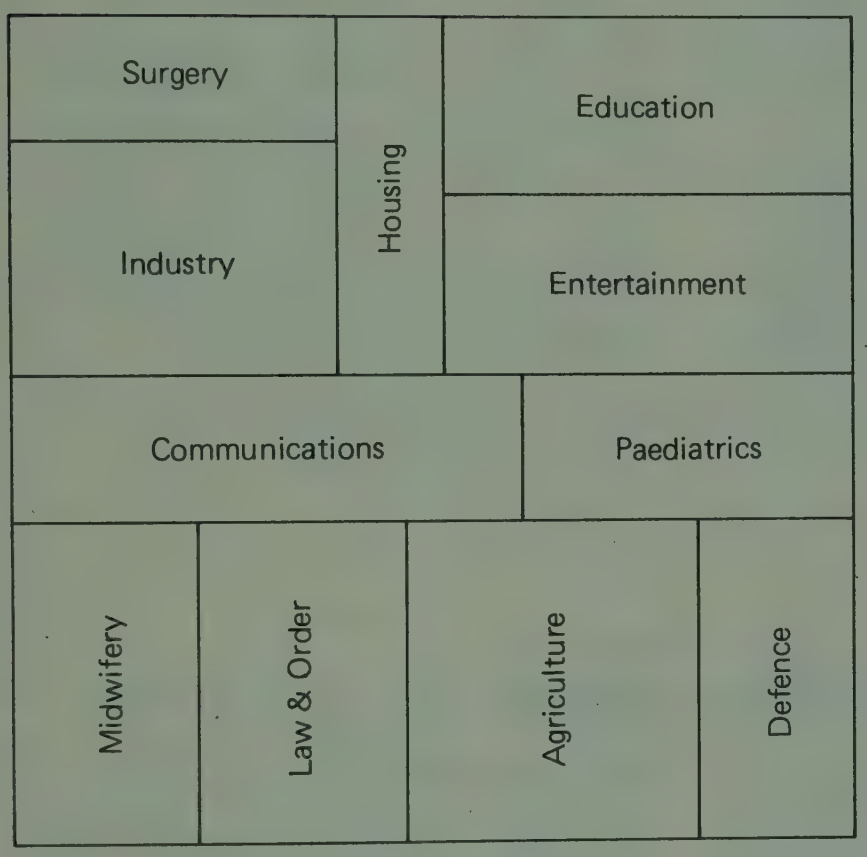
Now (Stage 3) concepts and methods formerly peculiar to public health have become so central to medicine that they change the dominant concepts of health and medical care. As a result, for example, the success of a medical procedure is no longer measured by the summation of its effect on the same pathology in a number of individuals. Instead it is measured by considering its effects on a whole number of factors previously considered to be the interest solely of other specialties as diverse as agriculture, education, political philosophy, transportation and industry. This is illustrated in Diagram 1B.

Notice how the new multivariant method of assessing a good result has as its corollary a new model of health which is constellated and political.

As this new model begins to dominate, it begins to make claims for cure based solely upon the measurement of only one factor (e.g., infant child mortality), which is as self-evidently absurd as it would be under the "traditional" model (e.g., to claim adequate success since all the patients' legs were cured though all the patients died of the same disease!). The final stage of this tendency to move from the concept of health as the eradication of all disease from individuals towards the concept of health as a vital balance of a constellation of factors in acceptable proportions and political harmony is represented by Diagram 1C below:

Diagram 1C (Compare 2C)

The Public Health Concept of "Health"



The philosophy of health implicit in the public health approach has been radicalized within medicine: now a "health" report is inseparable from a "state" of the nation report, and vice versa.

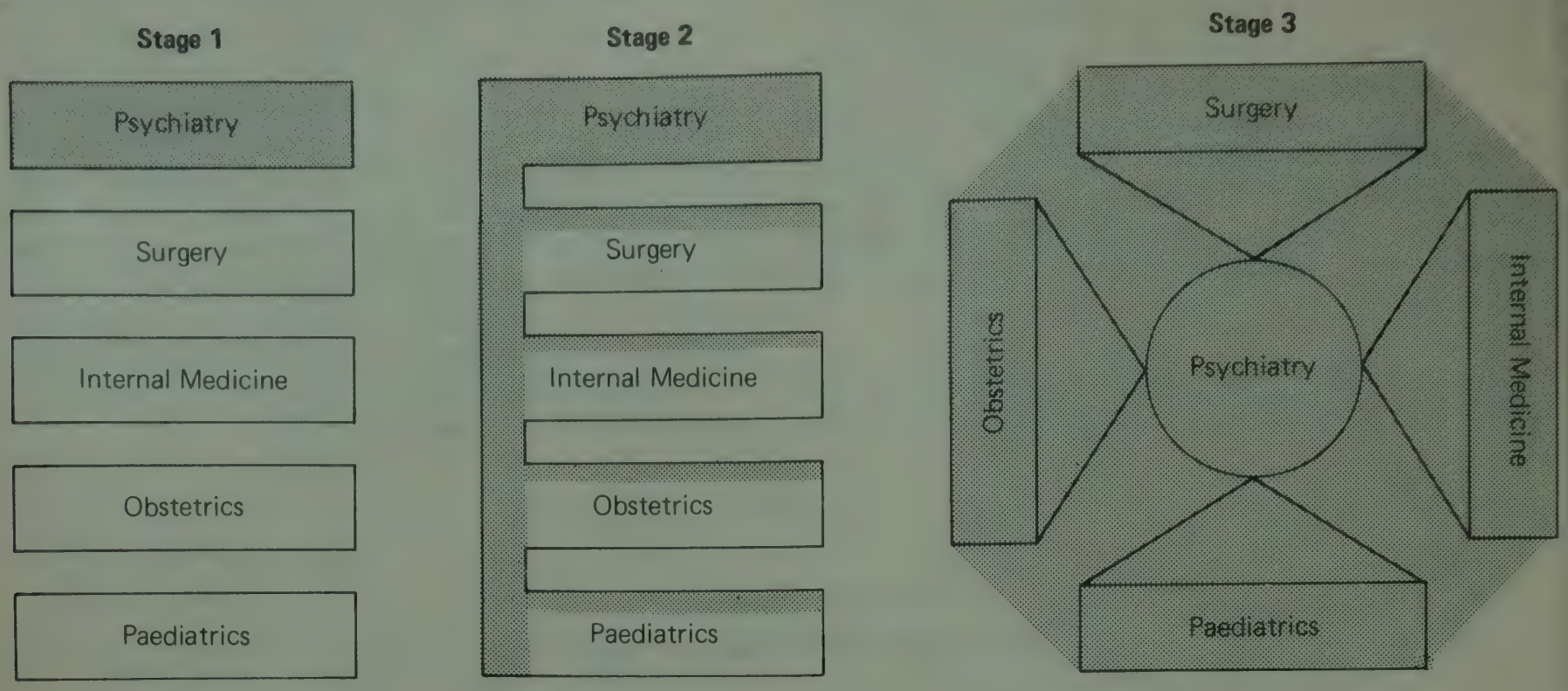
The concept of "HEALTH" and the concept of "JUSTICE" now inseparable.

The point being made is that public health has not only made an important impact within its own field but has changed the whole concept of health. It is not just a shift to a preventative view. It is not just that health is no longer seen only as the removal of disease from an individual and the health of a nation as the summation of such work on such individuals, it is also a shift from an individual to a corporate multivariant view of health so that now a nation's health report can clearly be seen as a report on the whole politico-economic state of the nation. This change can be indicated by saying that **public health concepts of medicine have been radicalized to the point at which "health" and "justice", whilst remaining different notions, can no longer be considered as separable notions.** One indication of this is that medicine has become politicalized to the point at which (see diagram above) political maturity is seen not only as a *means* of health but as one *measure* of health!

Let us now develop the analogy between the influence of public health on medicine on the one hand and of psychiatry and mental health care on medicine on the other hand. The diagrams which follow illustrate the comparable stages:

Diagram 2A (Compare 1A)

Influence of Psychiatry and Mental Health Care on Dominant Concepts and Practices of Medicine



Healing is the personal management of individual diseases. Psychiatry is a separate specialty. Psychodynamics is knowledge about individual psychosis or neurosis only.

Now there is psychological awareness in personal management of all individual diseases. Psychiatry is beginning to affect the concept of health, but psychodynamics is still only to do with psychosis or neurosis.

Each single disease seen now as an example of a disturbance in an interpersonal psychological situation. Psychiatry is now changing the concept of health, of how it is pursued, and by what criteria it is measured.

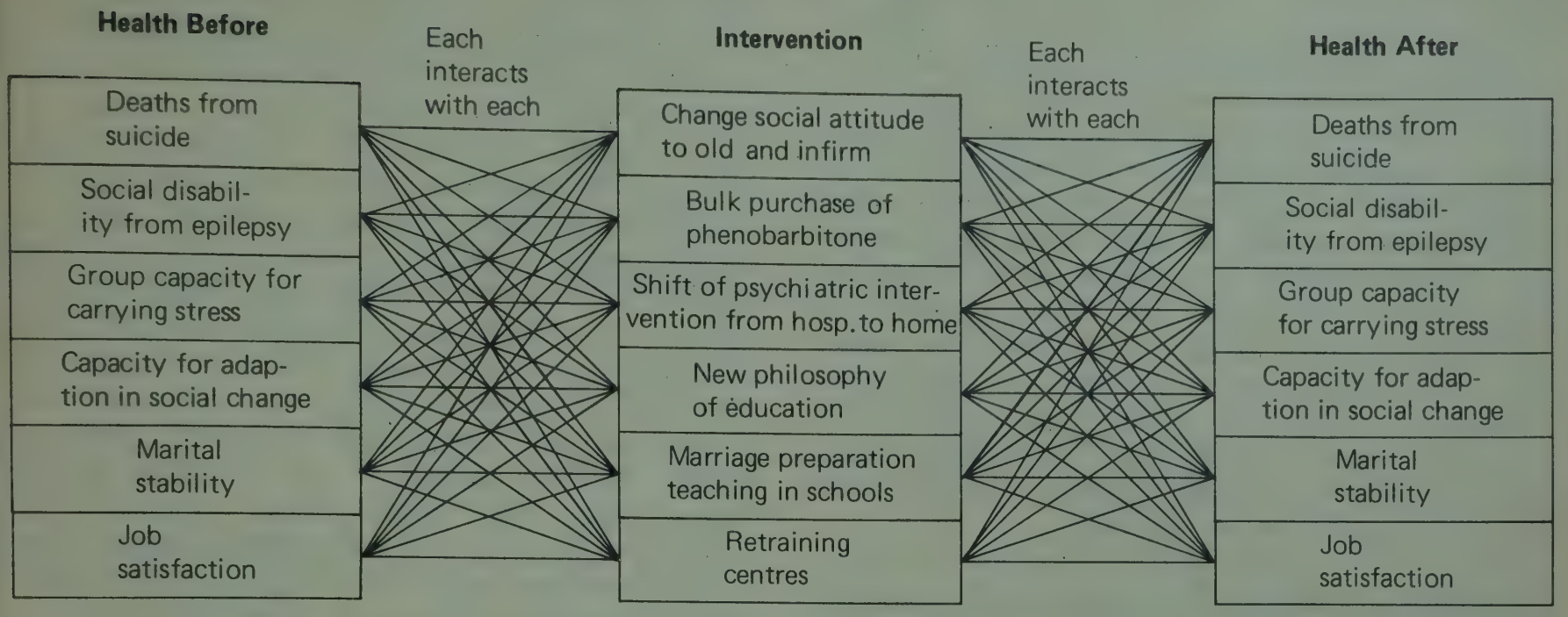
Hatching represents influence of psychiatric concepts.

From the diagrams we can see that whilst psychiatry can exist as a separate discipline concerned to care for individuals with psychiatric illness, it can also, like public health, begin first to influence the approach to all types of diseases as traditionally understood and eventually become a unifying concept which changes the understanding of what health is and by what criteria it is to be measured. Finally, just as the radicalization of the public health approach to medicine produced a situation where "health" and "justice" can no longer be considered as separable notions, so **the radicalization of the psychiatric approach to medicine produces a situation where "health" and "persons in harmonious living" (love) can no longer be considered as separate notions.**

As public health can revolutionize medicine by changing the concept of health so that it becomes close to the idea of a political utopia, so psychiatry can revolutionize medicine by changing the concept of health so that it becomes close to the idea of a community in a state of ideal wholeness and well-being. The result of this will be to introduce multivariants into the measurement of interventions in disease situations as they are increasingly introduced in the developing practice of comprehensive health care. However, in this case these multivariants will be concerned with what are considered to be desirable personal and interpersonal qualities. (Probably these will tend to be denoted in recognizably psychological terminology and supposedly legitimated by psychological science, whereas in the past they were denoted in recognizably ethical terminology and supposedly legitimated by theology. Comprehensive mental health care practices inevitably disseminate views about what is the best way of living our lives. They will be highly conditioned by the brand of humanism congenial to the professionals who develop them.) This means that diagrams to illustrate programmes of proposed medical action and the criteria to measure the resultant effects may look like this:

Diagram 2B (Compare 1B)

The Interaction between Programmes Expressing the Influence of Psychiatry and Mental Health Care



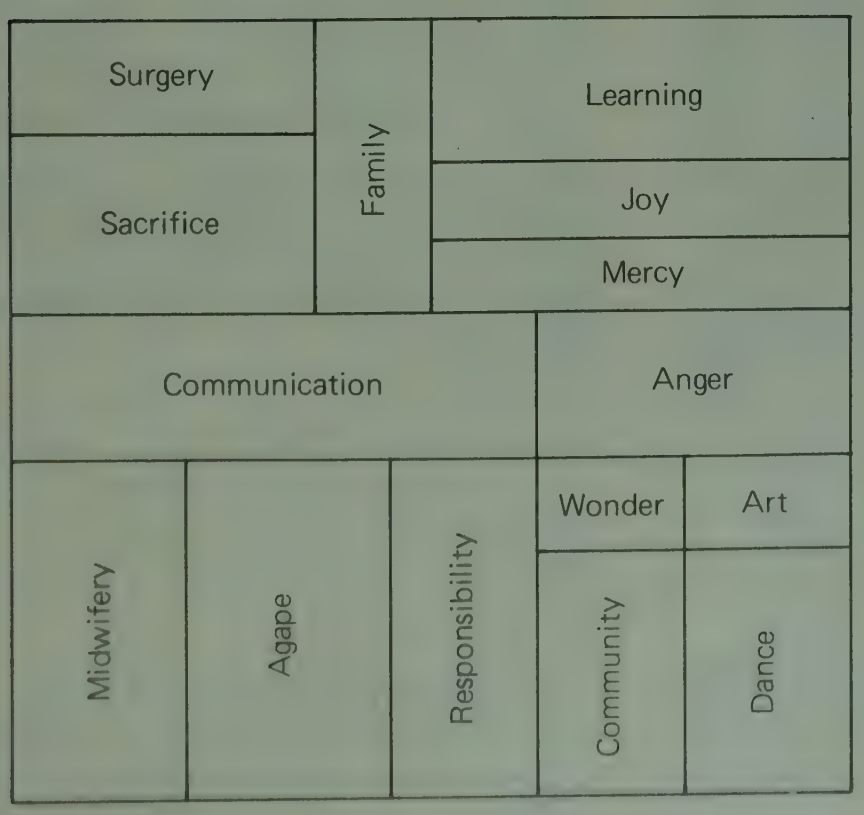
And it means that the introduction of psychiatric concepts into medicine become radicalized to produce a new concept of health in which the notion of "health" and the notion of "an ideal state of souls in fellowship" are no longer separable.

The end result of this impact of the "public health" concept on medicine is to bring the philosophy of medicine closer to the philosophy of "politics" largely conceived of as a technological task. The resultant type of comprehensive health care will tend to be numerate, managerial and power-conscious, in which health will be conceived of as one amongst many material possessions to which every human being has a right.

The end result of the impact of the "psychiatric" concept of medicine (see Diagram 2C) is to bring the philosophy of medicine close to the philosophy of "love" largely conceived of as a personal task of interpersonal relations. The resultant style will be literate, obedient, imaginative and humble, in which health will be conceived of as a surprising joy to which every human being comes by grace.

Diagram 2C (Compare 1C)

Community Integrity and Love



Psychiatric approach has been radicalized and "health" report inseparable from "state of souls in fellowship" report, and vice versa.

"HEALTH" and "LOVE" inseparable.

The two combined look like "shalom".

We see then how the changing processes of secular medicine and its technological shifts are invitations to us to perennially transcend our previous understandings of health and of the health care system which brings mankind closer to health. **If public health concepts imply a "political" revolution in medicine, psychiatric concepts imply an "experiential" revolution in medicine.** We have already seen how political community participation may be advocated not merely as a means to community health but as one criterion of community health. Similarly, the manner in which men and women experience their own and others' illnesses, healing and health may become an inseparable part of the definition and measurement of illness, healing and health. What does this mean for the future of medical mission?

As we become increasingly conscious that men and women can choose the criteria by which to measure the health towards which they can be assisted by health care, the challenge to medical mission becomes more evident. They are challenged firstly to discern with those they serve what health might mean for them and secondly to act with those they serve to bring that health nearer. For health is God's continual activity, and medical mission is called to be fellow workers in that activity.

For an example of the implications of this we can ask what are likely to be the challenges of the "experiential" philosophy of health to the generalized acceptance of those comprehensive health care ideas which we can hopefully expect in ten to twenty years' time. The challenge will not take the shape of a revival of the individualism which comprehensive health care exponents now very properly attack. But it may well take the shape of a new emphasis on the interpersonal experience of persons confronted in themselves or others with disease and a complaint that the quantification methods, quite properly employed in comprehensive health care, have grossly underweighted in their human accountancy that concept of health which regards it as the optimum "experiential" response of men and women in community to their suffering.

By "experiential", I mean to indicate a unity of "inner" and "outer" and "subjective" and "objective" so that community participation is seen as both personal and political (if we must make such a distinction). For the new poor created by comprehensive health care may well be those whose care requires more expenditure of medicare than an easily measurable distributive justice allows. (The logic of this position is that the care of the incurable is injustice!) The chronic schizophrenic might be such a person; unproductive, irrational and incurable, a comprehensive health care based upon a rational distribution of scarce resources does not merely seem to allow his social rejection but to demand it! But on the other hand, supposing our concept of a healthy community includes as a criterion for its measurement a growing capacity of persons to be hopeful, loving, helpful and sacrificial in the face of "unbearable" situations, then the neglect of such persons — on the basis of the obvious lack of "good results" required by distributive justice — is seen to be as illogical as the previous neglect within the "traditional" health system of those who did not present themselves as sick at hospital.

It seems then that if, as I believe we should, we seriously consider the possibility that psychiatry and mental health have an increasingly important part to play in Christian medical mission in the years to come, we should take a long careful look at why we think it important. The danger is that we may make the same mistakes again and transport to other countries, along with our psychiatric departments and mental health programmes, philosophies of man which say as much about the weakness of the West as they do about its strength. (What about our own attempted suicide rate, alcoholism rates, boredom and acquisitiveness?) The use of anthropologists and sociologists to master the ways of life of other peoples in order to innovate programmes for improving the physical health of such persons needs great sensitivity and humility if it is not to be an affront to human dignity. If the same powerful and rational tools are used in a psychiatric or mental health programme, this demands even greater sensitivity and humility if it is not to be an affront to human dignity. Are Christian medical missions capable of such sensitivity and humility? Old questions like the relation between evangelism and persuasion will arise again but in new forms. In the end the relation between healing and salvation proves to be as real for the doctor as the theologian!

CHAPTER VIII:

TRADITIONAL BELIEFS, HEALTH AND CHRISTIANITY

A study of change among the Wape people of Papua New Guinea

by Mr Donald McGregor

Published originally as CONTACT 14, April 1973.

THE HEALING OF MONDA

In early January 1972, Monda from Teloutei village became sick. Her skin was cold and clammy, and her head and chest and whole body ached. Her stomach pained as it rumbled. Although there was no vomiting or diarrhoea, she ate little. Very sorry for herself, she lay on her "pangal" bed much quieter than usual. Concerned, husband Kauyu called for Wilaki, one of the medicine men in the village. Feeling Monda's cold skin, Wilaki immediately concluded that ancestral spirits had afflicted her. Wilaki then informed Monda and everyone else that her sickness was the result of her bad behaviour. Maiweiyum, Kauyu's mother, who died in 1961, had grown tired of hearing Monda insult Kauyu. Time and again Monda had also said nasty and untrue things about her husband to others in the village. In frequent fits of temper she would belt her four children over the head (not the buttocks as Kauyu had instructed her); and to top it all, Monda was lazy. Quite often when Kauyu arrived home from tired and hungry, no sago had been prepared. Now Maiweiyum's spirit was angry with Monda. Why should her daughter-in-law behave like this when she, Maiweiyum had worked so hard to care for and feed her son Kauyu when he was a baby?

Wilaki told Monda her wrongs. Before she could be well again, she must determine in future to be a good woman. Then placing his mouth in turn over Monda's back, shoulders, sides and chest, Wilaki sucked and pulled out seven pieces of wood. Angered ancestors had shot these into Monda when she was in the bush. Also, Maiweiyum and others had taken part of Monda's spirit away from her. Consequently, her skin was cold. If her sickness was the result of spirits coming into her, her skin would be hot.

Hearing Wilaki's diagnosis, Kauyu set about making his wife well again. (The restoration of health to a sick person often involves the effort of a number of relatives. It is not solely the work of the medicine man.) Kauyu again told Monda her wrongs. She had sin, and this sin resulted in sickness. (Sometimes it is claimed that the sin is the sickness itself.) Before she could be well again, Monda must confess her wrongs and promise in future to behave properly, fulfilling her responsibilities. After Monda had made this confession and promise, Kauyu prayed to God to send away her sin — her sickness and also the bad spirits. Kauyu earnestly prayed to God for his wife on several occasions during the sickness, the main request being that God would send away Monda's sins.

That afternoon Kauyu blew softly on various parts of Monda's body that were paining, saying: "Mother, you go down and out of her." Somehow the spirit of his mother was in her, smiting her daughter-in-law, thus making her sick.

Early next morning Kauyu went to the bush. Picking various leaves, grasses and fern leaves from the garden where Monda had collected food when she first felt sick, he tied them into a neat bundle. Then quietly speaking to his ancestral spirits, to his mother and others, he said: "You put back the spirit of my wife, and she will be well again." Setting off back to the village, Kauyu carefully placed every few yards along the track an upturned fern leaf with the stem pointing homewards. Monda's spirit would follow these. Arriving home, he heated some stones in a fire and, when hot, placed them in the bundle of leaves. He then rubbed the heated greenery over Monda's body. While doing this, he blew in each ear and over several parts of her body, saying: "Mother, father, grandmother, grandfather, you must leave her alone, and she will get well. You put back her spirit, and she will be well."

Kauyu claims that next morning Monda was well again and went and washed. Since then she has been a much better woman, for she is afraid of Kauyu's ancestors.

Just why Monda has been so rebellious and difficult is hard to say. She may have had a difficult childhood, or perhaps it is the particular set of genes she was born with and is naturally a difficult person. But then we are all basically rebellious and self-centred.

A week or so later Kauyu came to Lumi and told me this incident of his wife's sickness. Through questioning, he told me the story as I have outlined above. But he really came to learn more about prayer. We had a good discussion about talking to God, which I believe was a help to him. Actually, Kauyu prays frequently, both privately and publicly, in his village and at the regular Sunday services I hold at Teloutei. And he often passes on to others in his hamlet what he has heard and experienced of God.

Although I did not personally see the above healing incident, on other occasions I have seen medicine men remove arrows, the ritual of leaves being heated and rubbed on the body, and the exorcism of spirits.

Kauyu paid medicine man Wilaki 50 cents for his services, and it appears that Monda is somewhat better behaved. She herself makes no claim of being a Christian.

There is more to this ritual than I have described, but it is enough for the purpose of this paper.

The geographical area in which these particular beliefs are held lies wholly in the Lumi Subdistrict of the Sepik region of Papua New Guinea. There are slight variations in the beliefs and ritual, but they are basically the same throughout this area. They are practised quite frequently, and sometimes educated men are involved.

PRINCIPLES WHICH MAY GUIDE OUR REACTIONS TO SUCH TRADITIONAL BELIEFS AND PRACTICES

What should be the approach of church workers to this incident, so typical of countless tensions and crises about which the local people are terribly concerned? It is not possible to give a simple answer, for there are many factors which need consideration. We can, however, make observations, evaluations and interpretations and so arrive at some important principles.

1. The above incident is more than just a case of sickness. It is necessary to diagnose it as malaria or pneumonia and treat accordingly, but there is more to it than this. Behaviour values, relationships, prayer, the problem of staying alive are all concerns in the situation. Ancestors do not exist separately from the material world in which people live. Everything and everyone, the natural and supernatural, live together in their one world.

2. It appears to us Europeans that the people believe contradictory notions. For example, in the above event the sickness is said to be caused by

a. Kauyu's mother taking part of Monda's spirit from her;

b. splinters of wood being shot into Monda's body;

c. ancestors smiting Monda;

d. Kauyu's mothers's spirit being in Monda;

e. Monda's sin, perhaps the sin being the sickness.

Of course, it is possible to somewhat harmonize these concepts. For example, Monda sinned, following which Kauyu's deceased mother smote her and then took part of Monda's spirit from her, following which the mother speared her with splinters of wood. When the sin was confessed, the arrows were removed; and through the appropriate ritual Monda's spirit returned. The removal of her sin by God either was or resulted in the removal of the sickness. But we are not at all sure that this is the way the people themselves put these ideas together. All we can say is that to them these concepts are either non-contradictory or the contradictions do not worry them. Probably the former is true.

3. These are not isolated beliefs which can be easily discarded or removed from the culture. With many more they provide a logical picture of the world in which events make sense and have meaning. As it stands, their world view is basically neither Christian nor non-Christian; it is simply their understanding of the world in which they live. It is neutral, but it can be christianized.

4. The world view of the people, which includes all basic assumptions (unconsciously held) and beliefs, gives and reinforces a system of values which for centuries has helped the people live together. The fear of retaliation by their ancestral spirits motivates them to follow these values, which are closer to the Ten Commandments than is generally realized. They have less fear of such things as sorcery and ancestral spirits when they follow their traditional values. The whole world view and value system is a fairly effective deterrent against the sins of stealing, anger, immorality, disobedience, laziness and not fulfilling one's accepted roles. If the truth be known, it is probably true to say that, at present, the traditional system is a much greater force influencing village people (including Christians) to live together without stealing, immorality, anger, etc., than is Christianity. Yet we need to realize that their traditional system is not always or even generally the antithesis of Christianity.

5. We should not aim at undermining their world view (not that we can anyway), for on this foundation is built quite a reasonable set of values. Rather than destroy their world view and values (and, we may add, their social structure and culture), we should think more in terms of its changing, developing and being brought to fulfillment. Rather than destroying a people's identity, self-image, security and history, we aim at being an instrument in enabling the people to travel the road of progressive change.

6. When missionaries try to authoritatively disprove the beliefs and assumptions of a people, there is inevitably a breakdown in communication. The native people then say that the European just does not understand, and discussion on the subject ceases. It has happened many times.

7. We may make a distinction between, on the one hand, the people's supernatural beliefs and, on the other hand, the ritual followed which is based on these beliefs and carried out in times of crisis. It can be argued that we have no scriptural ground for saying that it is sinful for the local people to believe that their supernatural beings have power, but that it is sinful for them to follow a traditional ritual in which spirits are entreated or appeased. If this is so, we next ask just how does a Christian expect God to deal with the spirits causing sickness? What is the relationship between God and their ancestral spirits?

When many people first became Christians, they believed that, as God is stronger than spirits, they would not in future get sick, that is, provided they did not sin. When they later did become sick, they followed what they knew: their traditional ritual. Many prayed to God as well. To them it was a very reasonable approach. And this is what Kauyu did.

8. We cannot, either from the Bible or the physical sciences, authoritatively or "once and for all" disprove their beliefs about sickness nor their view of the world. The Bible speaks of the existence of spirits and does not deny the presence of ancestral spirits (compare Saul's calling up Samuel's spirit, recorded in I Samuel 28). The physical sciences do not address themselves to problems concerning the supernatural or the meaning of existence or of values, judgement and reconciliation, all of which are present in Monda and Kauyu's experience. We cannot talk in terms of their world view being factual or non-factual, for that aspect of it which we are here discussing is not in the realm of the physical sciences. It is the supernatural. It is their spiritual reality, and we have no alternative but to accept it on its face value. This, however, is not the same as agreeing with it.

9. We are interested in bringing Christ into the situation. In the process of time these lesser powers may be brought under His control and thus used as His instruments; or He will send them away; or reliance on them will become superfluous and fear of them unnecessary; or God becomes the ultimate cause and the ultimate reality, and their traditional causality and reality come under God's power and authority; or it may be inevitable that the two systems exist side by side for some time until the people are brought, possibly through the instrumentality of a local Christian prophet, to the point of decision. At any particular point of time, how can European missionaries know what the specific relationship should be between God and their supernatural? Only people in the situation can come to some conclusion. This will become their theology.

10. Explanations of events, including both the "how" (science) and "why" (meaning, religion) within the framework of the traditional world view, may also have a deeper, non-conflicting, Christian interpretation. I will give an example. Ouye from Inabu, a Christian of some years' maturity, recently took a second wife. A few months later his second wife died. In February 1972, Ouye told me with much conviction of sin that his wife was taken from him by God in punishment for his sin. The next day we were discussing sorcery ("sanguma"). Without hesitation he said she was killed by "sanguma" and gave me the conclusive evidence. Then he remembered that he had earlier said that God had taken his wife. He believed that God allowed the "sanguma" to kill his wife and that in this way the "sanguma" was the instrument of God's judgement. Yet it is really quite irrelevant to try to reconcile the two statements, for they are non-conflicting. In this instance the "sanguma" was thought of more in the realm of science (the "how") and God's judgement in the realm of faith and religion (the "why"). And as with all peoples of all religions, the two realms are on non-conflicting levels. We can make the same remark about the incident concerning Monda and Kauyu. The Christianity Kauyu applied does not seem to conflict with traditional beliefs, and neither need there be any "watering down" of the Christian faith.

11. A relevant theology will not be a static thing but will change as their understanding of the world changes and as they grow in their Christian experience. However, to participants in the culture, at any particular time it will be thought of as absolute and final, though they will be aware there is more to learn from, and experience of God. Their New Guinea theology, adequately spelled out, will address itself to the problem of existence in their world and will have much to say about sorcery, ancestral spirits, sickness, death. The problem of existence refers not only to the task of staying alive but also to the meaning and events of life and the reason to be. A relevant theology will accept the existing world view and, in so doing, will be an

instrument for gradually changing it. In addressing itself to the tensions and fears of everyday life, it will show the Christian way to live in their world. This theology spelled out can only emerge from the people themselves.

12. If an expatriate missionary does not get a fair understanding and respect of the people and their traditional culture, including such things as the world view, value system, social structure, mythology, it is hardly possible for him/her to recognize or accept any valid indigenous Christian theology which speaks to the tensions of life. A relevant and valid theology we Westerners would almost certainly brand as syncretistic (in a bad sense).

13. It is inevitable that the people, in understanding and applying the unique (in many respects) Christian message, will reconcile it with their world view. Technically speaking, this would be syncretism. But it does not follow that it is necessarily bad. It depends on what it does to God. If it means God loses His transcendence and power and His character is thought of wholly in terms of one of their ancestral spirits, this would be a bad syncretism. However, if the people believe that whatever power the ancestral spirits have is either allowed of God or given to them by God and that He is the God of the universe and both transcendent and immanent, this could be a valid and proper syncretism. Actually, there are several possibilities; and the people in the situation are the only ones who can find the truth for themselves.

14. Our understanding of the nature of theology is a far too static kind of thing. Rather than dwelling on rigid structures, never changing creeds and doctrinal statements, we should be thinking about something much more fluid, related to life as it is. Unless a theology speaks to the issues, tensions, fears of life, it is not adequately spelled out. Local Christians and churches need to work out theologies which address themselves to the particular problems they face, for example, ancestral spirits, "sanguma", medicine men, food exchanges, bride price, obligations to relations, including the "wantok" system.*

Church workers and missionaries need a better and more realistic theology that gives better guidelines in our approach to culture. I think it is quite obvious that the theology we used for years (our evaluation of the culture in the light of our interpretation of the Scriptures) was far too black-and-white and rigid. We still hear missionaries saying that good customs can stay but bad customs must go. But customs cannot be neatly tabulated into these two categories, for there are good and bad together in varying proportions in practically all customs, with a thread of animism validating and reinforcing almost all. To condemn a custom because it has (in our view) some bad in it, quite ignoring the good it contains, has rather serious repercussions.

It is simply not possible for someone outside the culture to legislate what is right and what is wrong, what should go and what should stay, and when all this should happen. Those who try are as often wrong as they are right.

15. I sometimes think we have an overblown doctrine of Satan. New Guinea Bible school students are commonly taught that not only is sorcery ("sanguma") of Satan but also the work of the medicine man ("glass man"). The result is that some New Guineans have now worked out a theology concerning sorcery which goes something like this: "Sanguma" is satanic. A Christian wholly following the Lord and claiming His power and protection will not be afflicted by the "sanguma". However, a half-hearted Christian will not have this protection. If such a Christian has a sickness which is inflicted by the "sanguma", he must go to the medicine man (satanic) and have the splinters of wood removed from his body. When well again, he can wholly follow God.

Does the medicine man's power really come from Satan? Some New Guineans are beginning to question this, and I for one am not at all sure we can say that all the work of traditional medicine men is of satanic origin.

Sometimes local Christians mouth what we teach them but (unconsciously), in fact, do not really believe all we say. They may accept but not believe it. The teaching has not gone through their whole being, including their conscience or intellect; nor is it related in some way to their understanding of the world.

16. A number of Christian men are being taught at theological seminaries, Bible schools and other centres. We are expecting the leadership of the churches to come from these institutions. Through the teaching they have received during the two, three or four years they have been away from their home environment, it is inevitable and right that their traditional world view will, to some extent, be changed. However, until we realize that New Guineans have a world view different from ours, it is almost inevitable that in teaching our particular understanding of life and our interpretations of the Scriptures, we subtly pressure them into accepting our world view. We virtually say that such things as the belief in their traditional spirits who make people sick is a lie of Satan who has darkened their minds; sickness has natural causes; ancestral spirits do not really exist, for when a person dies, the spirit goes immediately to either heaven or hell; the work

---

* Pidgin term from "one talk", one language, i.e. same tribe, group or nation.

of medicine men in pulling out arrows is trickery or satanic, as also is sorcery. Maybe we convey all this more implicitly than explicitly, but this is what we often teach.

New Guineans want to accept and believe all we teach, for they often think we are the guardians of the truth. In genuinely trying to believe all we say, they try not to believe their traditional understanding of the world, endeavouring to put it out of their minds. They cannot really reason and think it through, for much of what we say is not logical to their way of thinking. This results in repression, which has numerous, serious consequences. It hinders intellectual honesty, fosters hypocrisy, duality, legalism and deadness. It hinders healthy creativity and the development of the mind, personality and whole being. Yet it often happens that the students repress much of their world view at these institutions in which they are trained, only to result in it all coming out later in times of crisis when they return to their villages. Students should have full liberty to first discover and discuss their traditional world view with the complete right to accept or reject according to their intellect, spiritual understanding, conscience, new information and their understanding of the Scriptures.

I think we need realize that we are not going to get a consensus of opinion from them that a particular world view is the correct one. For some reason individuals differ considerably in their ability to change. Education is a significant factor, as also is the particular society to which a person belongs. We should give complete liberty to each individual to weigh up, evaluate and freely discuss with others. Then he/she changes at his/her own rate.

A principle basic to Christianity is that of openness. Right through the New Testament Christ and the inspired writers appeal to the mind and conscience. They ask rhetorical questions which stimulate the whole being into facing issues. Partly in this way intelligent and correct decisions are made.

A society cannot completely change its traditional world view within the span of a few years. If people could, it would mean the collapse of virtually their whole belief system – their logical understanding of the world in which they live and on which their value system and social structure is built. If these go, the roots of the society are destroyed. The few individuals who seemingly manage to completely change their world view (through being away from their society and in an institution) are often forever cut off from their own people.

17. God has placed in the heart of every person a mechanism which enables him/her to distinguish between right and wrong. Also known as the conscience, this mechanism, activated by the Holy Spirit and the Scriptures, enables individuals and groups to increasingly learn of God, His ways, and to discern the real values and behave accordingly.

Another mechanism God has given us is the mind, by which we learn and interpret facts. Aided by God, the mind enables individuals and groups to increasingly learn of God's world and understand it better.

We also need to remember that the intellect and conscience of the local people operate wholly within their world view and value systems from which they cannot be divorced. The logic we use and the ethics we communicate have to make sense in their world view. This will gradually change, but we have no alternative other than to work initially within this framework.

We expatriate missionaries often bypass (or ride roughshod) over the people's mechanisms of intellect and conscience in our endeavour to have local Christians exercise their wills in the way we think they should. In so doing, we often persuade them to act in a way that makes little sense either to their reason or their conscience. For example, a man said to me, "Why don't you Europeans like us 'blowing' on a sick person? We only want to get the bad spirit out of the person. If we don't do this, the sick will die."

Our attitudes and words sometimes make the mind and the conscience of local people become inoperative and tend to bring them into a legalism, hypocrisy and dualism. We also make them forever dependent upon us and do not learn to hear the voice of God in their hearts.

18. We have already noted that the local value system is much closer to the Ten Commandments than is generally realized. Romans 1 and 2 tell us that to all people God has revealed, through creation around them and conscience in them, some truth and light. We need to realize that conscience is moulded a lot through cultural values. In other words, in all cultures and even religions there is some light, some truth; and when recognized, this can be built on. In some sense at least, Christianity is the fulfillment of the local culture in the same way as Christianity is the fulfillment of Judaism. Perhaps Matthew 5:17 has an application here, "Do not think that I have come to do away with the Law of Moses and the teaching of the Prophets. I have not come to do away with them but to give them real meaning."

Christ can give real meaning to the local culture. In many respects Christianity is unique from all other religions. In other respects it is the fulfillment of cultures and religions. I have found that local people will discuss, given the right situation, traditional beliefs and Christianity. They keenly want to know what in their traditions is true, what is false, what is

partly right, and how the light from the Scriptures puts a new complexion on it.

There is an aspect of animism which says that stealing, immorality, anger, selfishness, not caring for old people, etc., is in sin and will be punished. We cannot say this is wrong or satanic. Instead of ignoring or discarding these beliefs, I think we should aim at working on this foundation, showing that the true God is the God of the ancestral spirits (Colossians 1:16); and that in breaking these laws (those which are also in Scripture), they are really rebelling against God. A number of Christians have of their own accord expressed similar views to me. Granted, they will not have our doctrinal purity (if there is such a concept) and their understanding of God will, to us, be excessively punitive (harsh); but it will be a theology that makes sense to them and that takes seriously their traditional values.

Our failure to realize adequately that God has given some light and understanding to people through their traditional culture has had serious repercussions. Directly or indirectly it has resulted in our

a. having insufficient motivation to learn the culture,

b. not having adequate respect for both the people and their culture,

c. being too authoritarian and "black-and-white"; this, in turn, has resulted in people hiding their actions from us,

d. not being able to discuss intelligently, seriously and sympathetically with the people life and all that it is.

19. We should have two aims:

a. To be an agent in helping the people form a Biblical, relevant and practical theology which addresses itself to life and that makes sense in their view of the world.

b. To be an agent in changing their world view; it is not contradictory seeking to both accept it and change it.

As church workers and expatriate missionaries, our attitudes and actions may be stated thus:

a. We refuse to be shocked or to pass judgement.

b. We have a genuine respect for people, including their world view, values and whole culture.

c. We ask questions in order to
   i. learn and, in so doing, understand and thus discuss intelligently and with love;
   ii. help the people better understand themselves, their situations and their world. In so doing, some of their unconscious is brought into their conscious. They view their beliefs and customs and values more objectively and are thus able to make more intelligent decisions.
   iii. Help the people develop and use their minds and consciences. To this end we openly discuss passages of Scripture which deal with existing tensions and allow people to make their own decisions.

20. We return to Monda and Kauyu. What should church workers say, do and teach in such situations? Teach about God, His willingness and power to forgive sin if we repent; tell of His love and understanding; and teach He is the God of their ancestral spirits; encourage the sick to get medical treatment and pray. I wish local Christians would tell such experiences in their church meetings and at conferences. For some reason (probably we missionaries are to blame) these common events are not considered appropriate testimonies. In true fellowship experiences are shared, whatever they may be. Life is told as it is. Indeed, will there be growth until life, all of it, is brought to God?

21. It is not so much the amount church workers and missionaries know about a people's beliefs and customs that is important. Rather, it is in the deepening relationships formed in the process of learning. Knowledge we acquire is of use only in enabling us to both form and deepen our relationships with people. What counts is our closeness, empathy, sensitivity and acceptance with men and women. The value of our knowledge is the extent to which that knowledge helps us do just this.

22. A good understanding of the local culture is necessary, but this is to the end that we see beyond traditional beliefs and customs and recognize the local people as people really quite similar to us. We should aim at taking the culture for granted, as something quite natural.

But the real solution comes when our main focus is not on culture or even theology but on the living Christ and His love and salvation. May Christ become our all-consuming passion, and may we instinctively and effectively use what knowledge of the culture we have along with a good theology as vehicles for communicating Christ to people in their culture.

CHAPTER IX:

THE HOSPITAL IN SOCIETY. HEALTH, ATTITUDES AND VALUES

by Dr Michael Wilson

This paper, originally presented to the Ontario Hospital Association in October 1974, was published as CONTACT 27, June 1975.

In his novel, *1984* (1), Orwell describes four ministries through which the party holds power: a Ministry of Peace concerned with war; a Ministry of Love for law and order; a Ministry of Plenty to deal with scarcities; a Ministry of Truth were a vast system of brain-washing is planned and executed. He did not need to describe a Ministry of Health concerned with disease: we already have one.

A MEDICAL MODEL OF HEALTH

In England, our understanding of health is based upon our knowledge of illness. Professions concerned with health care attend to the prevention, diagnosis and treatment of illness. The institutions in the Health Service (particularly those teaching hospitals where future members of the professions are trained) are founded upon the same concept: that health is obtained through the eradication of disease.

We find it difficult even to speak of health without speaking of illness because *our notion of health has been reduced to non-illness.* This clinical model of health shapes our very perception of illness and our pragmatic approach to its cure. Some of the finest achievements of this century, such as the heart transplant, some of the greatest endeavours of humanity, such as the world-wide spread of hospitals, owe their inspiration to a desire to conquer disease and relieve human suffering, but increasing technological skill is making a mechanical product of health.

It is therefore important to try and tease out the beliefs which shape our understanding of health and illness, and find expression in our practice of hospital medicine, in our styles of professional work. *Beliefs have expensive consequences.*

I suggest that our health care system is the victim of a built-in contradiction: that you obtain health by eradication of disease. As we increase our ability to discover defects in human biology and behaviour, the complexity of disease grows. Therefore, within our present conceptual framework — a medical model of health — there is no solution to the problem of illness. A system of medicine founded upon knowledge of disease does not produce health; it can only discover more disease and create the very needs which it is supposed to meet.

A hospital service can never be brought up to a desirable standard in terms of resources and staff. Because the more we look for disease the more we find, the more technological facilities we require to deal with it, and the more staff we need with more specialist training. To this process, with modern technology to help, there is no limit *until* a people becomes conscious that there is more to life than keeping oneself disease-free: and that is a choice of values.

Beveridge could not have been more wrong when he predicted that, after an interim period catching up on the backlog of illness, the cost of the British National Health Service would diminish. Since 1948, the Service has expanded continously, the logical victim of its philosophy. (2)

HOSPITALS

The most modern group of hospitals in Birmingham, England, is now referred to as The Medical Centre. It is important to examine the assumptions on which such a centre is based. The types of hospital which men build faithfully reflect their attitudes to life and death, illness and health; faithfully reveal in mud and wattle, or concrete and steel what man believes about himself, how he understands life, suffering and death; and how he responds to illness, whether by curing or caring, banishing or seeking to probe its causes. The hospital is a mirror of social beliefs about man in society. Beliefs shape buildings.

A hospital is one of the most powerful socializing influences in a country, comparable perhaps with the publicity media in its power to convey attitudes and values about life and death. Because we are human and reflect upon our experience, *a hospital is a living learning arena* in which patients respond to some of the sharpest crises that men and women ever have to face.(3) Every illness is a reminder of how vulnerable we are. We hold our treasure in a very earthen vessel. So important is this human response to the experience of illness, death and healing (experience which may make or break individuals, families or nations) that I would wish to describe the primary task of the hospital in society not in terms of cure or care or research – important though these unquestionably are – but in terms of human learning, thus:

> *"The primary task of the hospital is to enable patients, their families, and staff, to learn from the experience of illness and death how to build a healthy society."*(4)

Wether we would agree upon its significance or not, the process of learning, because we are human, goes on – *is now going on* – in hospitals. What do we learn in a hospital: this living, learning arena?

It is not easy to bring to consciousness for critical examination the assumptions upon which hospital medicine and nursing are based. Often assumptions are powerfully held because they are linked to the values, emotional fulfillment or prejudices of staff, patients and their families. But these assumptions are powerfully conveyed to all who take part in the life of a hospital. They form what might almost be called, "the Gospel of the hospital", the main tenents of which could be stated as follows:

a) That the cure of disease is more important than the care of people.

In Britain, this has immediate practical consequences in that hospital units which treat acute episodic diseases (particularly those which kill middle-aged males) receive priority in funds compared to units which offer little or no hope of clinical cure (notably for the mentally handicapped, people with long-stay emotional illness, or geriatrics). Such units tend to be short of funds and staff; they are of low prestige, and it is in these units that many immigrant nurses and doctors are employed.

b) That the provision of health is a task for the experts.

In hospital, we focus deliberately upon the individual patient. It has been part of the strength of hospital medicine for doctors to be able to isolate the patient, diagnose his disease and concentrate detailed research and therapeutic power upon a localized lesion or system. Important discoveries have been made tnrough specialism in medicine and surgery.

The disadvantages of specialism are not so readily admitted. One of them is that the word, "amateur", becomes a dirty word. More and more we look to "the experts" to do something about our health care for us.

Patients tend to regress for many reasons; it is often part of the disease process. It may also be part of the process of readjustment to a breakdown. The strong attitudes of staff engender an attitude of passivity and trust in those who know their job. This is entirely appropriate in so many conditions. But it is resulting in a society whose members are less and less willing to accept any responsibility for their own health care, and who look for short-cut solutions to every painful experience. The skill and strength of staff may make patients' families feel superfluous. After all, we can cure the patient without the family.

Very few patients are 100 per cent passive. Most are well capable of responsibility for helping to make a good recovery. The work of community therapy units has shown how it is possible to give patients a voice, to enable them to become agents.

Recent enthusiasm for team-work in hospital, so essential in an institution where professions multiply, may lead to even greater appearance of power beneath which the patient feels crushed, unless *the patient is also treated as a member of the team.*

The full burden of the emphasis on curative medicine, and consequent specialism is seen in the developing world (e.g., in Nigeria) where:

> *"Three quarters of our population are rural, yet three quarters of our medical resources are spent in the towns where three quarters of our doctors live. Three quarters of the people die from diseases which could be prevented at low cost, and yet three quarters of medical budgets are spent on curatives services."*(5)

There is no blueprint of how to be a doctor, nurse or social worker: our professional styles must adapt to the needs of the situation where we practise. Today, it can be argued, our medical style no longer meets the needs of society.

c) That death is the worst thing that can happen to man.

We are a death-fearing society and the practice of medicine and nursing is influenced by such social fears and expectations. We defer consideration of death to the end of life because we do not accept it as a part of what being human means. Hospital staff are at the receiving end of a social taboo on death and feel death as a failure. Such are group dynamics that ward staff will attempt to deceive patients, and a doctor will resuscitate elderly and clinically

unsuitable patients to the point where one must ask: whose needs are being met — patient's, staff's or family's?

Death, the great insoluble incurable fact, is denied. Death is believed to be dominant over life. Sartre vividly describes in his novels the resultant meaninglessness which has spread through life.

Medicine cannot but share in this loss of meaning, for the style of being a doctor is influenced by the society and culture of the day. Prolongation of life is not necessarily good in itself. It is a possibility for good or evil. There is more to being human than just being well. It is not the doctor's fault if his powerful skills to prolong biological life bring greater problems to humanity in terms of quality of life; if the man or woman whose life he has saved lives on into an old age of poverty and a sense of worthlessness. *It could be better to die young, alive, than to live old, dead.*

Over a century ago, Darwin pointed us to the meaning of biological death in the evolution of the species. Teilhard de Chardin calls death, "The great lever in the upsurge of life." It is not the end of life we have to fear, but *the death of quality in our lives here and now.*

> *"Is it not strange that men may die before their bodies do,*
> *And women's souls fade from their eyes?*
> *Where have they gone?*
> *Tis strange but it is so."*(6)

In social terms, a society may "kill" (may treat in a way which spells death for) those of whom it disapproves, those whom it fears, those by whom it feels threatened. So society excludes (kills, sometimes literally) either by its attitudes, by segregation, institutionalization or execution, the bad, the mad, the black, the widow, the leper, the aged, the underprivileged, the mentally subnormal, the rebel, the dying and the poor. Medicine has its hand, for better or for worse, in the development of social attitudes to the ill, the deviant, and to death.

These are some of the assumptions which underlie our professional styles of health care in the Western world. Because we do not consciously examine these ideas, they are powerfully conveyed to those who take part in the life of the hospital, and through them to society.

We have spoken of the hospital as a living, learning arena. We have described some of the lessons which are being learned and, above all, the implication that health is to be obtained by the eradication of disease. This is a fallacy. But it may be very difficult to perceive the situation in any other terms. Our perceptions, our language, our institutions and styles of health care are shaped in the clinical model of health. We must now go on to ask: what then is health? How do we understand illness if we base our knowledge of illness upon our understanding of health, rather than our knowledge of health upon our understanding of illness? What practical implications follow for hospitals from such a profound shift of concepts: a veritable conceptual repentance?

HEALTH

At different times and in different cultures men have seen health differently. It is a word that has stood for the way in which a people see what might be called, "the good life."

> *"The Navaho conception of health is very different from ours. For him health is symptomatic of a correct relationship between man and his environment: his supernatural environment, the world around him, and his fellow men. Health is associated with good, blessing and beauty: all that is positively valued in life... The Navaho does not make the distinction between religion and medicine that we do; for him they are aspects of the same thing..."*(7)

The Jewish concept of Shalom, literally, "peace", was very similar:

> *"Shalom is not something that can be objectified and set apart. It is not something which can be enjoyed in isolation. Shalom is a social happening, an event in interpersonal relations. It has to be found and worked out in actual situations."*(8)

Health is a concept related to the culture of a people. It cannot be defined absolutely, but it can be recognized and described as different people seek to work it out in actual situations.

Another concept of health is given practical expression in the army. If the sickness rate in an army unit rises, the commanding officer will look at the unit's *morale.* He will take general measures to raise the morale. Not only will he survey their conditions of service, but he will also look to the whole purpose of the unit and see that the unit's task is understood. Working to raise morale is the result of a different perception of illness to that of the health care service where an increase in illness would be countered by (say) more hospital beds and more staff. The work of Revans has also shown how, in different hospitals, the sickness rate among student nurses is an indicator of high or low morale.(9) He has also studied morale in relation to pit accidents.

Over the last twenty-five years, *public health* has had a profound influence on our own ideas of health and shown us that, not only has health *a social dimension,* but that, in concerning itself with water supplies, diet, and compulsory vaccination, it has a

political dimension. The question of priorities raises matters of *political choice:* political because health concerns the quality of our life together in a family, a neighbourhood, a nation, and internationally; a choice, because our resources are limited.

Likewise, over the same period, *psychiatrists* have introduced a new cluster of criteria for the evaluation of individual and social well-being. We must now include *interpersonal factors* such as acceptance or prejudice, ability to adapt to social change, attitudes to old age and death, and the stability of marriage and family life in our evaluation of the health of a society. These criteria can be seen to contain ethical assumptions.

Health, then, is situational; that is, it is related to what a people believes to be fullness of life for them. And in seeking health, they must choose between different factors in a world of limited resources. *Health is, therefore, an ethico-political art.*

In his research work on job dissatisfaction in industry, Hertzberg distinguished (but did not separate) two sets of factors.(10) Job dissatisfaction was related to the conditions in which work was done: wages, canteen facilities, time off, and so on. These he recognized as fulfilling the worker's basic biological needs. He called them *Adam factors.* Job satisfaction was related to a distinct set of factors which are more difficult to evaluate; they were related to the nature of the work, whether the worker shared in making decisions, whether the work was fulfilling and offered wider scope in the future, the type of leadership. These factors he called *Abraham factors* (because Abraham was a much more adventurous, more fully human person than Adam). And these factors are related, not just to the needs of the human being as a creature, but to the human being as a person.

In the same way, there are a whole range of Adam factors and Abraham factors which we may describe in relation to health. There are man's Adam needs for basic hygiene: food, water, shelter, clothing, and among these factors we must include non-illness. This is the wider social context within which we compete with other hygiene provisions for our basic biological needs such as agriculture, housing, care of the environment, water, transport and schooling. All these, in addition to being well, make for our biological satisfaction. It is in these that we are affluent, but affluence does not guarantee health or high morale.

Man cannot *live* by bread alone. There are also man's Abraham needs which relate to interpersonal harmony, responsibility, sense of purpose and meaning, human dignity, communication, and sacrifice. In Great Britain, we are surfeited with provision for our Adam needs, yet we sometimes speak of a sick society. In an African village, there may be a heavy burden of parasitic and other diseases, almost no hygiene provision whatsoever; yet the people are distinguished for two things: their generosity to strangers in *sharing* the little that they have, and their *capacity for celebration and dance.* These might be two of the criteria of a people's health. They prompt the question: *how much basic hygiene is enough to make health possible?* I deliberately put the question in this way because health is rather like telling a joke. You cannot be certain that people will laugh. In the same way you can make full provision for a people's basic hygiene needs, but you cannot be certain that they will be healthy. Health comes as a surprise, as a gift, beyond our own contriving.

ILLNESS

In the light of what we have said about health, what new things may be said about illness?

It is a commonplace that much illness may be recognized as a disease of interpersonal relationships in a family. There are hospitals which now admit the whole family, not just the disturbed individual. Or better still, send a professional to the home situation where distress arises.

Illness may further be seen as a form of social communication. In my own hospital in Africa, three of the commonest diseases were malnutrition, veneral disease and tuberculosis. They were found in labourers from the Northern Territories who came one thousand miles south to seek work. They were exploited as temporary labour, and the diseases from which they suffered were symptomatic of poverty, overcrowding and separation from family.

Stress disease may also be best understood in social terms, rather than individual terms, as a form of social communication which exists in individuals, calling attention to a sick style of life.

> *"We all share in this suffering, though only certain people bear it."*(11)

Suicide, accidents, obesity and smoking, those factors which feature in the present ill health of the nation and which contain an element of personal responsibility, can be viewed as indicators of morale.

There is evidence that, when we speak of illness, we are describing a complex of human responses (to a situation) of which body pathology is only one. Surveys have shown that large numbers of people who are well — functionally — show the same kinds of body pathology as others in hospital who are ill. Equally important are the reasons why people go sick when they do. Zola, for example, has described personal, social and racial differences in response to bodily signs.(12) And if a doctor treats pathology

only, without also discovering why the patient has gone sick when he has, the patient is more likely to discontinue his treatment and the healer has lost the chance to deploy his art.

There is still in these widening approaches to disease a profound rejection of the experience of illness, of painful experiences, of suffering as intrinsically bad. McMurray wrote:

> *"It is not possible to develop the capacity to see beauty without developing also the capacity to see ugliness, for they are the same capacity. The capacity for joy is also the capacity for pain. We soon find that any increase in our sensitiveness to what is lovely in the world increases also our capacity for being hurt. This is the dilemma in which life has placed us."*(13)

This is not a plea for resignation in the face of disease; that would be to betray human endeavour. But it is a plea to distinguish destructive and creative suffering, for a more profound diagnosis of the place of pain and suffering in growth towards greater humanness. Health positively includes suffering as a creative way of dealing with hostile and destructive feelings. Indeed it seems that the very existence of a healthy society requires some who are ready to bear the consequences of their own and others' folly, for bearing one another's burdens.

> *"In fact, there could be no full health without sharing the burdens of sickness, so that a perfect health service where training, organization and equipment totally removed the need for self-sacrifice is a logical impossibility."*(14)

Hospitals can no longer cope with the problems that are being presented to them. There is a change in the pattern of illness. One of the distinctive developments in our society over the past twenty years has been the growth of voluntary societies such as Alcoholics Anonymous, the Samaritans (suicide), the Richmond Fellowship (emotionally ill), Gingerbread (one-parent families), the Cyrenians (vagrants). All these societies provide long-term, costly, personal care. It is as if there is a *cri de cœur* from people seeking a personal model of healing. We need one another's technology, but we also need one another.(15)

We must take seriously the social disharmony of which stress disease is a symptom, help the patient in his own family and work situation towards new insight, and give continuing support as he digests what is often a painful experience.

At this point, we must change our perception of illness. Illness has a voice. We must move from ideas of therapy to ideas of learning. Illness is a learning experience. And the word "doctor" means "teacher".

In a community therapy unit, the doctor can already be seen in his role as interpreter and teacher. In Nigeria, Morley has shown how a doctor can be primarily a teacher.(16) In an under-fives' clinic, the doctor is a teacher wo supports the nurse in clinical and educational work, face to face with mother and child. A very similar experiment in Britain is the work of a practice nurse, who is able to take a great deal of primary care work off the shoulders of general practitioners.(17) And our health visitors are that rare profession in health care, who function among the healthy in non-crisis situations. (18)

No one can foresee quite how the health care systems of the Western world will develop. We have reached a crisis, and to be able to see one step ahead is probably all we can hope for. There are important philosophical changes coming. I have tried to indicate their shape. Fundamentally, I think our beliefs about the nature of good and evil are involved. The incredible advance of medical knowledge and technology since the war has given every encouragement to those who perceived illness as something which was to be overcome, an enemy of mankind. And in the relief of human suffering we shall continue to cure, to operate, to treat and to fight disease, although we are steadily getting more and more mechanized in this field.

With the clearing away of the more obvious infections, however, *disease at a deeper level of the person, especially the "self in relationship", has become evident.*

Most illness cannot now be viewed as something which can be cured, exorcised or treated as an entity which is separable from the person. *We are all — together — both well and sick.* There is some inner harmony to be established if we are to be healthy.

Now we are faced by illness which must be borne; illness from which we must learn, understand and wrestle health; illness as a symptom of social disease; illness to deal with for which we need not only technology but one another. Illness is not necessarily the enemy of health.

From what I have said about health and illness, certain practical implications follow. In spite of our cultural preference for single thrust solutions, there are in fact no such solutions. Rather, there are many small suggestions to be carried out over a wide front.

PRACTICAL IMPLICATIONS

1) We need to *reshape our beliefs* about health and our understanding of illness. The reformation of beliefs and attitudes is essential if we are to escape the inherent contradictions in our health services which are inexorably increasing their size and cost. But financial factors apart, *we as a people need once again to be able to choose a style of health which*

can enhance our humanness. This needs a new perspective; we are partly responsible for the whole, not wholly responsible for a part.

2) Doctors particularly are facing a *professional identity crisis.* If the work of a doctor is to be thought of as a balance between the two poles of therapy and teaching, then, today in the West, the balance needs to move towards the teaching pole. Doctors, particularly in the developing world, are already facing this with courage. There is an account of what this means in practice by a surgeon, trained in the USA, who found himself working in a largely rural part of Korea.(19) In the Western world, the changes required are no less sharp. Part of this change depends on a new valuation of the role of social workers and nurses, who, in many spheres, are well able to work as colleagues to doctors rather than as aides.

3) A new consciousness of *the role of the hospital in education for health* does not mean the immediate introduction of new types of educational unit. It means *making use of existing opportunities* for listening, conversation, group discussions. The work of psychiatrists in community therapy units indicates the kind of joint enterprise in which both staff and patients listen and learn together. The seminars of Dr Kübler-Ross with dying patients have shown that often it is the patient who has something to teach staff; both learn together.(20) Dr Kübler-Ross is simply making full use of clinical opportunities for education. Education for health is not simply an extra to be tacked on for those who like that kind of thing. It is what health and illness are all about within the movement of humanity towards greatness.

Every time a doctor meets patients and families, there is a ready-made learning opportunity. Staff in hospitals need look no further than their own clinical material for learning from the experience of illness and death how to build a healthy society. The importance of the health service as an information service for society is clear. Information about the symptoms and signs of what is going wrong in a society may be more important than treating those symptoms which, in the long run, could conceal the real trouble. The prominence of stress diseases today is a social warning which must not simply be solved or tranquillized out of sight and mind.

4) Inevitably, this kind of understanding of illness will involve a new emphasis on *the primary care of patients in the community.* The work of Balint has shown us how patient and physician shape the course and outcome of an illness between them.(21) It is in the early stages, when a patient is still in his own context, and when the illness is relatively unshaped, that understanding may be most fundamental. Hospitalization tends to harden an illness into the kinds of clinical syndrome which both staff and patients can tolerate. We have learned a lot about institution-shaped illness.

5) Given a wider understanding of health in society, the health care service is then accorded its proper authority in the field of prevention, diagnosis and treatment of disease. But *health planning belongs to society more widely.* To discuss health, one must have present, in addition to hospital professions, housewives, artists, ministers of religion, teachers, environmentalists, architects, industrial leaders, and so on. Within this context, hospital technology becomes a good servant for use on a human scale in ways that meet the criteria of society. In our British revised Health Service, we have appointed local Community Health Councils with this purpose of giving the public a voice.

6) Two general practitioners in the UK spent every Thursday evening last summer meeting a different group of their patients, for refreshment and discussion about the work of the practice. They went on to discuss what kind of *health centre* they might build locally and what facilities it should have.(22) The design of a health centre is a sensitive indicator as to what we mean by "health". The Peckham Health Centre of thirty years ago and our modern health centres are quite different in aim and structure.(23) A modern centre is a polyclinic, well equipped for the diagnosis, prevention and treatment of disease. The Peckham Health Centre was a family centre, equipped with library, swimming bath, restaurant, stage and play areas. It aimed to enhance the quality of life in a deprived area. The medical laboratory subserved this aim.

Not only do our beliefs shape our buildings, but our buildings shape our beliefs.(24) The design of a health centre influences the attitude and perception of those who use it and grow up with it as part of their assumed philosophy about what health is. New imaginative designs can influence people's attitudes.

7) Caplan describes people in society whom he calls *culture carriers.* These are key people in the local life of street, town, and hospital, whose conversation and attitudes shape public opinion. Such people would be germinal in any change of understanding.

The many volunteers in hospital and voluntary services in the community can likewise be a leavening influence in their neighbourhood. Today, you almost have to go on a training course before you can visit your grandmother! It should be possible to unscramble (as it were) a regular proportion of volunteers and send them back into the community with the simple instruction to be a neighbour and never call themselves anything else.

8) The relationship between good *morale* and sickness rates (noted in the army and schools of nursing education) is worthy of further research.

Two factors, the size of the unit, institution or community, and the type of leadership are important. The opportunity to understand and share responsibility for the task of the unit also has an effect on people's sense of meaning.

In selecting the matter of morale as worthy of further research, I have obviously made an ethical choice: therefore...

9) Because health is a matter which involves choices of value, *ethical sensitivity* is required for a community to grow. Denied its value content, health must become a clinical or political shuttlecock.

T.S. Eliot wrote:

> *"The first important assertion is that no culture has appeared or developed except together with a religion: according to the point of view of the observer, the culture will appear to be the product of the religion, or the religion the product of the culture."*(26)

The importance of the relationship between religion and culture is that it provides the essential basis for making ethical choices; it also provides a future vision which gives a sense of direction to our present work. We need some lectureships (if not a Chair) in some subject such as *Health and Human Values,* but better still, men and women who are alert to ethical questions and who will, within their present profession, ask ethical questions about their work.

It is easy to drift into the situation where we try to make the clinical facts or the financial facts make our decisions for us; this is another name for expediency.

Recently the Duke of Edinburgh, speaking in Australia, said:

> *"Until it can be demonstrated that science, technology and economic growth can take the place of religion and provide that essential inspiration and motive which has created all great civilizations in the past, it would appear that our culture is simply free-wheeling on our Christian inheritance.*
>
> *"The very essence of most religions... is that they provide the only satisfactory alternative to expediency in making judgements and decisions on the important issues which each generation has to face."*(27)

I suggest that the most important question which we face today is: what do *we* mean by health? (28)

BIBLIOGRAPHY

1. Orwell, George. *1984,* (Penguin), 1954.
2. Macmillan, Donald. "The Infinity of Demand", in *N.H.S. Reorganisation: Issues & Prospects,* ed. K. Barnard & K. Lee, (Nuffield Centre for Health Services Studies, University of Leeds), 1974, p. xii.
3. Hunter, T.D. "Self-run Hospitals", *New Society,* Sept. 14th, 1967, pp. 356-358.
4. Wilson, M. "The Primary Task of the Hospital", *The Hospital,* Vol. 66, Oct. 1970, p. 346.
5. Morley, D. quoted by M. King, "Medicine in Red and Blue", *The Lancet,* 1972, Vol. 1, No 7752, p. 679.
6. Turner, Walter James. "Reflection", *Oxford Book of Modern Verse,* ed. W.B. Yeats, 1936, No 269.
7. Read, Margaret. *Culture, Health & Disease,* (Tavistock), 1966, p. 25.
8. Davies, J.G. *Worship & Mission,* (S.C.M.) 1966, p. 130.
9. Revans, J. (1) *Standards for Morale,* (O.U.P.), 1964. (2) "Management, Morale and Productivity" in *Proceedings of the National Industrial Safety Conference,* (ROSPA, London), 1963, p. 84.
10. Hertzberg, F. *Work and the Nature of Man,* (Staples Press), 1968.
11. Bally, G. Comments on an address "Illness & Health in the Community of Mankind", *Study Encounter,* (World Council of Churches), 1966, Vol. II, 3, p. 152.
12. Zola, I.K. "Pathways to the doctor — from person to patient", *Social Science & Medicine,* I, 1973, pp. 677-689.
13. McMurray, J. *Reason & Emotion,* (Faber), 1935, p. 46.
14. Lambourne, R.A. Quotation not traced: probably from an address to students.
15. Wilson, M. "Violence and non-violence in the cure of disease and the healing of patients", *The Christian Century,* 1970, 87, 24, p. 756.
16. Morley, D. *Paediatric Priorities in the Developing World,* (Butterworths), 1973, Chap. 19.
17. Smith, W. & O'Donovan, J.B. "The Practice Nurse — a new Look", *British Medical Journal,* 12 Dec. 1970, p. 4,673.
18. Clark, June. *A Family Visitor,* (Royal College of Nursing, London), 1973.
19. Sibley, J.R. "The Koje Do Project — Progress & Problems", *Contact,* No. 5 (Christian Medical Commission, World Council of Churches), 1971.
20. Kübler-Ross, E. *On Death & Dying,* (Tavistock), 1969.
21. Balint, M. *The Doctor, His Patient and The Illness,* (Pitman Medical), 1957.
22. Cull, T. & Bird, A. "Patient-doctor seminars", *Journal of the Royal College of General Practitioners,* 1974, 24, p. 247-250.
23. Crocker, L.H. & Pearse, I.H. *The Peckham Experiment,* (Sir Halley Stewart Trust Publication, Allen & Unwin), 1943.
24. Wilson, M. *The Hospital — a Place of Truth,* (Institute for the Study of Worship & Religious Architecture, University of Birmingham, England), 1971, p. 125.
25. Caplan, G. *An Approach to Community Mental Health,* (Tavistock), 1961.
26. Eliot, T.S. *Notes Towards the Definition of Culture.*
27. H.R.H. the Duke of Edinburgh, "Universities & the Diffusion of Culture", *Frontier,* 1974, 17, 3, p. 137.
28. Wilson, M. *Health is for People,* (to be published by Darton, Longman & Todd, London), 1975.

CHAPTER X:

THE CHURCH'S HEALING MINISTRY IN AFRICA

by Mr Kofi Appiah-Kubi

This article was published originally in CONTACT 29, October 1975.

The theme of the forthcoming Fifth Assembly of the World Council of Churches, "Jesus Christ frees and unites", is a very consoling, meaningful, yet provocative and disturbing one indeed. The freedom and unity in Christ encompasses total liberation and salvation, an all-embracing salvation which concerns the whole person, without restriction. It is a widely accepted fact that salvation, at least in modern theological thinking in Africa, does not concern only the life after death (the afterlife), but also this world, the life here and now.

Especially to the numberless poor, sick and suffering population on our continent, health is an important aspect of the whole question of salvation: freedom and unity in Christ. For many here, salvation is a sign that, with the coming of Christ, suffering and death are eliminated and these will have no place in the Kingdom of God established here on earth by Christ.

To many, Jesus came that we might have life, and have it more abundantly. And yet the nagging question is: where is this abundant life in the midst of poverty, misery, sickness and suffering? The answer places the onus on the church's healing ministry. How far has the church, which is the embodiment of Christ and His ministry on earth, taken seriously the command of the Master: "Heal the sick, cleanse the lepers, raise the dead, cast out devils... freely ye received, freely give."? (Matthew 10:8)

It could be argued that the church, through her various mission hospitals, has achieved a great deal in alleviating the physical sickness of the African Christian. But, unfortunately, this was done without any serious consideration of the people's own conception of the world in which they live and of the forces operating in it (the people's world view), a conception which undoubtedly influences or determines their understanding of health and disease.

The church, through her medical centres and the use of modern scientific methods, has overstressed the importance of physical medicine and treatment to the total or near total exclusion or rejection of spiritual healing. Therefore, Jesus Christ, who is the Lord of all life including the African life, is often absent in the life crises of the ordinary Christian — at birth, puberty, marriage, pregnancy, sickness and death.

The conspicuous absence of Jesus from almost all these crises raises a host of questions in the mind of the African Christian. The knotty question here is: how do we reconcile what we preach with what we believe and practise? How can the church, through the uniting and freeing process of Christ, help to create a healthy population in a healthy society? What does this mean to you, brother or sister: "Jesus Christ frees and unites", while at every turn of your life you meet anguish, agony, poverty, disease and suffering? What kind of liberator is Jesus? Part of the answer, I sincerely feel, is that it is incumbent on the church to reconsider her healing ministry in Africa in the light of the African world view, which determines the African's understanding of health and disease, an understanding which in every way includes spiritual, mythical and physical aspects. In the church's attempt to bring salvation to the whole person through her healing ministry, she must emphasize the mystical, spiritual and physical understanding of health and disease. The treatment should include both spiritual (psychical) and physical approaches.

For too long, the healing ministry of the over-Westernized mission churches has been secularized to such an extent that it has lost its sacred character, its social control function, its subjective influence on society, its meaning in moral terms.

THE SOURCES OF ILLNESS

The unfortunate division between mind and body, spiritual and physical, sacred and secular, has

reduced the expected impact of modern medicine on the African population in terms of their understanding of health and disease. Most traditional African societies regard illness as a misfortune which involves the whole person. This has a direct bearing on the relationship of the patient with the spiritual or supernatural world and with the members of his society.

Illness is often attributed to the breaking of a taboo, or the machinations of malicious or sometimes displeased ancestral spirits. Other causes may be the evil eye, witchcraft, possession by an evil spirit and a curse by a sorcerer or an offended neighbour. It is also believed that the victim himself may not be the offender, but may suffer from the sin or offence of a relative.

Even though most Africans recognize the natural causes of certain illnesses, this does not preclude the simultaneous role of supernatural causes. For every misfortune, like any piece of good fortune, involves two questions: the first is how it happened and the second is why. The "how" is answered by common-sense empirical observation, but the "why" is not easily explicable. Beliefs in witchcraft and other supernatural powers explain why particular persons, at particular times and places, suffer particular misfortunes: death, accident, disease, barrenness or crop failure. It is the "Why me?" question that the Africans ask and to which they seek an answer, an answer in which they link social problems to divine action. The belief in evil forces as a cause of misfortune and disease is part of the African answer to the general problem of misfortune and the existence of evil in the world.

Natural events and morality of social relations are interrelated. To the African, society, its natural environment and its members form a single system of morally interdependent relations.

As far as the African peoples are concerned, suffering, misfortune, diseases, and accidents are all caused mystically. To combat the adversity or ailment, therefore, the causes must be found and confronted, uprooted or punished. For the common people, however, religion is very largely the means of reinforcing life, of proper precautions against powers which might destroy them. It should be noted that the Africans make no distinction between religion and medicine, as is the practice in most Western societies.

Most Africans think that health is symptomatic of a correct relationship between people and their environment, which includes their fellow beings; the natural as well as the supernatural world. Health is associated with good, blessing and beauty – all that is positively valued in life. Illness, on the other hand, shows that one has fallen out of this delicate balance.

Concepts of health within the framework of African culture are far more social than biological. In the mind of the African, there is a more unitary concept of psychosomatic interrelationship, that is, an apparent reciprocity between mind and matter. Health is not an isolated phenomenon but part of the entire magico-religious fabric; it is more than the absence of disease. Since disease is viewed as one of the most important social sanctions, peaceful living with one's neighbours, abstention from adultery, keeping the laws of the gods and people are all essential in order to protect oneself and one's family from disease.

It is therefore quite clear at this stage of the discussion that the traditional theory of illness and methods of healing are integral parts of how people conceive their culture and world view. In most African societies, therefore, healing thus combines psychology, psychotherapy, religion and herbal medication. The healing ceremonies involve confession, atonement and forgiveness. Thus except perhaps in the case of very old people, natural death is not envisaged. When straightforward remedies fail, as in the case of illness unresponsive to normal treatment, or in time of calamity, recourse to the traditional priest, soothsayer or practitioner is necessary. The traditional healer therefore plays a central role in the health of the African.

THE PRIEST-HEALER AND SPIRIT POSSESSION

No serious discussion about the role of the traditional priest-healer in Africa will be adequate without making some reference to the phenomenon of spirit possession. Most of the traditional healers operate with the great powers they claim to have through spirit possession.

When possessed, the traditional priest-healer is able to give advice, prescribe medicines, help in the recovery of lost articles or diagnose some chronic diseases, such as acute madness, leprosy, blindness, impotence or barrenness, and, in some instances, failure of crops and other business enterprises.

However, by some misinformed and uninformed theorists, the spiritually possessed priest-healers are considered to be mentally ill. Their calling, according to such theorists, is believed to be the resort of inadequate and maladjusted neurotics and hysterics. Scholars have, thus far, tended to explain away the spirits by regarding them as primitive interpretation of social, psychological and physiological forces. But strangely enough, the idea of spirits is: there is God, there are angels and devils and Christian and other religions. My question therefore is: there is God, there are angels and devils and there are human beings; but how is the contemporary Christian, Muslim or Jew to understand references to spirit possession in his holy books?

The existence of the so-called primitive religion and spirit possession has been a cause of perplexity and doubt among church leaders, both foreign and national. There has been a tendency on the part of the church to condemn the indigenous religious and medical practices as evil and primitive, and to regard spirit possession and all the practices that go with it as regressive symptoms of the maladjusted personality, the victim of social frustration and pathological delusion. But are they?

Nana Abena Safoaa was born in 1859, in the small town of Obomeng in the Eastern Region of Ghana. She was the eldest daughter; her parents had had two sons, but they had never managed to have a baby girl. Three daughters in succession had been still-born.

It is said that Nana Safoaa was the first surviving daughter of her parents. Her birth was therefore received with mixed feelings: on one hand, the parents were overjoyed, but on the other they were extremely anxious to keep this child alive. Their behaviour was not totally unknown among many anxious parents in Ghana in those days, when the desire for children was a paramount reason for marriage and infant mortality was at its height. Especially in the matrilineal Akan society, the birth of a daughter meant more to a couple, for it was through her that the line could be continued; the absence of a daughter in a marriage was therefore considered a failure of the marriage.

Nana Abena Safoaa became seriously ill forty days after she was born. The anxious and despairing parents tried all forms of treatment to save their daughter. When all formal treatments, both scientific and traditional had failed, they went to a traditional diviner as a last resort; as they suspected there was some kind of supernatural power behind it all.

The diviner announced that the child had been selected by the spirit of a god called Opeagoro. Opeagoro was a god in the mother's clan, but when there was no one to look after it, it went out of practice for generations. It was this god who wanted Nana Safoaa to be its priestess. The diviner therefore told the parents to bring the following items to prepare the treatment: twelve eggs, two hens, a dove, a brass bowl, a piece of white calico, a calabash and some bottles of schnapps. After some consultation with the possessing spirit through prayer of libation, the diviner concluded that the spirit demanded these items as component parts of its shrine. The daughter would only be spared if the parents made a vow and kept their part of the contract that their daughter would be the priestess of Opeagoro when she became of age. The parents agreed and pleaded with the god to spare the child at all costs. The pact was made and the shrine was left in the care of the diviner until the child was mature enough to handle the affairs of the god. The hens and the dove were killed ceremonially for a sacrificial meal and the blood was used to seal the covenant. The parents were asked to report at the shrine every forty days. From that day on, these attacks of fits which had been diagnosed as epilepsy ceased and never disturbed the child again.

When Nana Abena Safoaa reached the age of puberty, the necessary rites were performed and the shrine was formally transferred to her home. The diviner was paid his fees accordingly. It is often the practice of most competent Ghanaian healers never to take any fees until their clients are fully recovered. The deposit is often used to purchase the items necessary for the treatment. From the age of fifteen onwards, the possessing spirit started coming to Nana Safoaa. By this time, she knew how to handle the spirit and the shrine. The spirit often took possession of her after every forty days. On some occasions, she could invite the spirit by prayer of libation and pouring a calabash full of water on the ground. She often preferred to use rainwater at such times. When she was possessed, she would divine, warn her clients of some pending disaster, or some coming blessing; she could speak in tongues and also foretell the future. She had great healing powers and she healed many patients of various complaints. One area where she earned her lasting reputation was in helping barren women and impotent men to be fruitful. Several childless couples were blessed with children through her help. She never charged most of her clients, but they had to pay for the required materials for the preparation of the treatment. However, she was often rewarded with gifts of sheep, goats and chicken and foodstuffs, and sometimes some of the satisfied clients worked on her farm to show their gratitude. Above all, most couples named their children after her, which in fact is the greatest honour you can do to an Akan.

Nana Abena Safoaa married at the age of seventeen and had many children and grandchildren. She was a farmer by profession. She died in 1962 at a record age of 103. The present writer is one of the twelve children of her eldest daughter.

Some sincere modern researchers in the field are unanimous in stating that the priest-healers are usually shrewd, intelligent and accepted members of their communities. They are expected to be sincere, honest, forgiving and pure at heart. They give advice, warnings or orders which help to maintain the moral and social order of the community. Through their help the anxious and the innocent are encouraged. They symbolize the hopes of the society, hopes for good health, protection from evil forces, security, prosperity and good fortune, and ritual cleansing when impurities have been contracted through a possible breaking of a taboo.

By expressing public opinion, mediating in disputes, reflecting the consensus of the community and demanding goodness, the possessed priest-healers are accepted as friends, pastors, doctors, social workers, advisers, psychologists and psychiatrists. In fact, in the field of healing broken bones and limbs, the traditional priest-healer has gained great importance and respect where some modern well-equipped hospitals have failed to succeed. For example, in 1962, the District Sports Organizer of the Eastern Region of Ghana had a very serious car accident. He was immediately admitted to the military hospital in Accra, at that time the best staffed and equipped hospital in Ghana. After some weeks, the specialists decided to amputate a leg and an arm. The man's family was consulted, but they decided, against medical advice, to remove him and try traditional medicine. He was sent to a shrine famous for treating broken bones. After some months of treatment the man regained the use of his limbs.

Ghanaian society is rife with accounts of this nature and one cannot but recognize with admiration the role of the traditional priest-healer in such matters, be he Christian or otherwise. Thus, in some instances, Western-trained physicians and psychiatrists have in recent years come to accept the increasing importance of the priest-healer in the prevention and treatment of diseases as these are understood by the Africans.

A good number of African intellectuals are sceptical in these matters. However, in spite of this, some African governments have gone so far as to endorse the medical practices of the priest-healers as well as those of Western-trained physicians. In Ghana, for example, the Government encourages and supports the Pharmaceutical Association which researches in, and promotes the use of, traditional African medicine. In Liberia, too, we hear that the use of traditional medicine is strongly encouraged even by highly qualified, Western-trained medical specialists. The value and respect for traditional medicine and the priest-healer is very high both in the rural and urban areas, among the educated and uneducated, the Christian and non-Christian population in Africa today.

Among most Africans, misfortunes including diseases are divided into three categories according to the causes: natural, preternatural and supernatural. Hence, it is necessary to take a herbal potion to deal with the physical or natural aspect, to carry out a magic ritual to reverse the preternatural element, and to make a sacrifice to placate the supernatural agency. It should be noted that, in most African societies, disease and misfortune are religious phenomena, and it requires a religious approach to deal with them.

HEALING: "THE GIFT OF GOD TO HIS BELIEVING COMMUNITY"

But what has the church done so far in her healing ministry? It is precisely at this point that the indigenous African Christian churches have made a breakthrough. They believe that total personal healing of the spiritual, psychological and physical person is the gift of God which He pours on His believing community. Like many other Africans, these churches also believe that disease is a misfortune which has natural, preternatural and supernatural causes. Unlike the missionary-oriented churches, which told their African converts that witchcraft and *ju-ju* were, at best, un-Christian and at worst, a lot of superstition and rubbish, the indigenous African churches accepted these forces as agents of the devil. By accepting the reality of the lives of their converts, they provide also the antidote in the power of God, Christ and the Holy Spirit. In so doing, they acknowledge the fact that, in African societies, religion and medicine stem from the same source and that, for many Africans, health is the most important of all concerns. They explicitly indicate that hospitals alone cannot deal with witchcraft and evil forces. Even though some of these churches totally reject the use of any physical medicine, most of them accept this medicine as well as faith healing and the two go hand in hand; or at times, when scientific methods fail, people resort to spiritual healing. But, in general, most people supplement conventional cures with religious ones.

The indigenous African Christian churches' approach to healing does not aim at supplanting medical treatment but at supplementing it. Their healing message through prayers, visions, dreams, laying-on of hands, and the use of consecrated water, olive oil and ashes aims at dealing with the practical problems of life, just as the indigenous African religion did and still does to a large extent. It is, in fact, hard to reject the existence of spirits, for the Bible in many places speaks of the "familiar spirit", for example, I Samuel 28.

Some scholars maintain that these churches resort to faith healing because of the shortage of medical services and doctors in Africa. But experience and research point to the contrary, though the shortage is a reality. However, the belief in mystical spiritual and physical causation of diseases calls for a wholistic approach to healing. This assures the church members of the power of a living, loving and caring God. For them, God is the power by which they can overcome their daily worries, concerns and fears, and the source of their entire life; He is not merely God of the gaps.

Even where treatment has been given, Western medicine alone fails to get to the root of the

troubles, for these may be psychological or spiritual in origin. This is especially true in the medical problems of women where fears, tensions and barrenness are often interwoven.

These churches further believe that the power of all modern medicine and sometimes traditional African medicine is good, but that this is nothing without faith; and God, the all-knowing and all-seeing, gives meaning and fulfillment to the work of humanity. Their therapeutic and wholistic approach to disease and healing is a breakthrough in the integration of healing with pastoral care and the message of salvation.

The social meaning of disease and healing is another cardinal point in the therapeutic activity of these churches. The activities of the faith healer parallel those of the traditional priest-healer, the modern physician and psychiatrist. In the areas of chronic psychiatric problems, such as alcoholism and drug addiction, the faith healers in the indigenous African Christian churches have made strides towards curing such patients; this is an area in which modern psychiatry is still groping in the dark.

As an illustration, a nephew of mine in the fourth grade of school became addicted to drugs and started drinking excessively. The parents were compelled to withdraw him from school, and this meant the discontinuation of his education. Through persuasion, they managed to apprentice him to a driver to learn driving. After some years of struggle he managed to get his driving licence. He became a taxi driver in Accra. During his stay in Accra, he met a girl whom he loved dearly. She was a member of one of the indigenous African churches in Accra. His love for the girl drew him into the church where the girl promised him that the Spiritual Father could cure him through prayers. The young lovers frequented the church and took their praying sessions very seriously. After some time my nephew became cured of his addiction and alcoholism. They got married and remained members of the church. Today, my nephew is completely cured. He has become a self-employed transport owner, and has made a success of his business. He has become a normal person again, much to the surprise of most people who knew him before as a mental case.

Leaders and members of these Christian churches claim, and quite rightly so, that their churches are not only churches but hospitals too. For the commonest reply to the question "Why did you join this church?" is: "I was ill for a very long time. I tried all forms of treatment, to no avail, and the doctors declared me a hopeless case. I was advised by a friend to go to prophet or prophetess so-and-so, the leader of an indigenous African Christian church; I did and now I am better." Complaints range from incurable diseases to impotence or barrenness, and it is in these matters that these churches are at their best.

CONCLUSION

What has emerged in this analysis is that in the causation of disease and its treatment in Africa, three elements stand out: those of morality, natural processes, and the mystical process. Disease and healing are a concern of society. In recent years the church has started talking about "wider ecumenism", meaning sincere and genuine contacts with other religions and faiths. But in many African societies, religion is not merely talked about, but lived. There is no room for theologizing in the abstract, as with Christianity. As one leader of an indigenous African Christian church said to me recently: "We Africans not only believe in God, we know God, we *live* our religion", while in most Western societies, as far as disease is concerned, the hospitals take over with their pills and prescriptions where the church leaves off with her spiritual and sacramental care. In most African societies and especially among members of the indigenous African Christian churches, religion is not divorced from medicine. There is a wholistic approach to health and disease.

The indigenous African Christian churches can best be described in this sense as the "integrationists" who, in their approach to health and disease, combine all that is good in African cultural, religious and medical practices with the modern scientific and Christian elements. In this way, they cope with the root of the needs of their African adherents. They emphasize the fact that Christ was concerned with health and disease. In an attempt to communicate this concern, the mission hospitals have tended until now to treat the patient as a physical object: a case, a number and a candidate. One of the chief complaints by most African patients in these modern church hospitals is that the doctors speak *about* them but not *to* them, look at their charts and take their temperature but do not touch them as persons. The reverse is true about the priest-healers and the faith healers. In most mission churches a priest is a priest and a doctor is a doctor. What goes on in the church has very little or no relevance to what goes on in the hospital.

A serious study of the traditional African beliefs with regard to health and disease, as implicit in the behaviour and beliefs of the priest-healers and the faith healers and their clients, could be of extreme importance to the church and the community she serves. The wholistic approach to health and disease observed by the priest- and faith healers of the indigenous African churches can help to renew the whole approach of the church's healing ministry to the problem of health and disease, at both practical

and theoretical levels. African converts to the missionary-founded churches have been effectively conditioned to treat all traditional medicines and faith healing as reprehensible paganism and quackery. But are they?

The church will do better in her healing ministry if she integrates the traditional priest-healers, faith healers and other local medical experts into the service. Why can't the church hospitals take such accepted experts on sick calls, invite them to divine the source of the sickness and where possible include them in some paraliturgical forms of service, either in the church or at the hospital?

The belief that "the whole person is ill" is very prominent in the healing process in Africa; this has fully been taken up by the faith healers in the indigenous African churches, hence the application of religion, psychology and psychotherapeutic approaches to all diseases. Christ said: "Heal the sick, cleanse the lepers, raise the dead, cast out devils; freely ye received, freely give." (Matthew 10:8) And the indigenous African churches answer: "Our churches are not only churches, they are hospitals."

"Belief, ritual and spiritual experience: these are the cornerstones of religion, and the greatest of them is the last."

BIBLIOGRAPHY

Adair, J. :"Physicians, Medicinemen and Their Navaho Patients". Iago Gladston (ed.): *Man's Image in Medicine and Anthropology.* New York: New York International Universities Press, 1963.

Appiah-Kubi, Kofi. *Spirit Possession, Christianity and Pentecostalism in Africa.* Unpublished thesis, Oxford University, 1973.

Field, M.J. *Search for Security.* London: Faber & Faber, 1960.

Frank, J.D. *Persuasion and Healing.* Baltimore: The Johns Hopkins Press, 1963.

Ghickman, Max. *Custom and Conflict in Africa.* Oxford: Alden & Mowbray Ltd., 1970.

Idowu, E.B. *Towards an Indigenous Church.* Nairobi: Mercury Press, 1965.

Lambo, T.A. "Neuropsychiatric Observations in Western Region of Nigeria". *British Medical Journal,* 2: 1388-1394, 1956.

Lewis, I.M. *Ecstatic Religion.* Aylesbury, UK: Hazell Watson & Vinery Ltd., 1971.

Margetts, E.L. "The Future for Psychiatry in East Africa". *East African Journal:* 37:6: 448-456, 1960.

Mitchell, R.C. *Sickness and Healing in the Separatist Churches.* Ibadan: University of Ibadan, Institute of African Studies, 1966.

Opler, M.E. "The Cultural Definition of Illness in Village India". *Human Organization,* Vol. 22, 1963.

Price-Williams, D.R. "New Attitudes Emerge from the Old. (The changing ideas of health and disease among the Tiv of Central Nigeria.)" *Proceedings* of the Vth International Conference on Health and Health Education, 1962, Vol. 5: Studies and Research in Health Education.

Prince, R. "Indigenous Yoruba Psychiatry". Ari Kiev (ed.): *Magic, Faith and Healing.* London: Collier-Macmillan, 1966.

Read, Margaret. *Culture, Health and Disease.* London: Tavistock Publications Ltd., 1966.

Rose, Louis. *Faith Healing.* Harmondsworth, UK: Penguin Books, 1971.

Williamson, S.G. *Akan Religion and the Christian Faith.* Accra: Ghana Universities Press, 1965.

CHAPTER XI:

THE EXPERIENCE OF HEALING IN THE CHURCH IN AFRICA

by Dr Hans-Jürgen BECKEN

This paper was presented at the Fourteenth Seminar for Christian Medical Mission at the German Institute for Medical Missions, Tübingen, Federal Republic of Germany, on 23 September, 1974, and published in CONTACT 29, October 1975.

INTRODUCTION

Our famous definition of the Christian church as a "healing community" seems to be an unsuitable one, looking at the individualism of Christians in the Western churches. Nevertheless, I feel the above-quoted definition to be correct according to the Scriptures. Taking for granted that Western theology is not regarded as the only valid expression of Christian theology on this earth, I propose to have a look at Christian theology in Africa, i.e., an interpretation of and a response to the Gospel by committed Christians who are living, thinking and speaking from their very experience of today's situation in the awakening continent of Africa. Thus, the question will be posed: does this regional — I hesitate to call it indigenous — theology provide the churches in the West with an insight that could assist them to come to a better understanding of the healing community character of the church?

To understand the concern of theology in Africa for the community, we have to trace back to the pre-Christian African religion and its thought structures. This religion did not have any equivalent for our Christian term "mission". The community of kin was identical with the cult community. There was no intention to convince a foreigner to become a member of this religious community, either by conversion or by baptism. Only by marriage was one crossing the boundary and entering another cult community. This irreversible step occurred once in a lifetime, as a person left the home clan with its particular veneration of the ancestors in order to join another clan with its own set of forefathers. This pre-Christian type of "mission" was by no means a "spiritual affair", it was en existential change involving the entire life relationships of the person concerned.

Christian mission in Western style offered, according to the missionaries' own experience, a spiritual salvation, and granted baptism and acceptance into the church upon an oral confession of faith. This practice was bound to result in syncretism: the convert put on Western clothes and attended divine worship on Sunday morning; simultaneously, he remained a member of his religious clan community in his everyday life. It would distort the historical facts to present this process in this isolated and one-sided manner, and there have been missionaries who learned the wholistic approach in their encounter with the people of Africa. However, in general, missionaries used to look with suspicion at a convert who expressed his new allegiance by rising to his feet and declaring: "I elect Jesus Christ as my Lord! " But it was exactly in this way that conversion was expressed according to African understanding, namely, that a person surrendered himself to a new community and to its Lord.

ENTERING "THE COMMUNITY OF THOSE WHO ARE HEALED"

This introduction is aimed at helping people understand a concept of thought structures which differs from the patterns of thinking to which people living in Europe and North America are accustomed. I have to add here that many of my African friends used to refer to this step over the boundary as described above as "healing" in accordance with their wholistic thinking. The members of the congregation have experienced this healing by joining the new fellowship of God and His people. Certainly, this is something different from discharging a person as "healed" from a hospital. It is also more than obtaining a membership card in an association or a club. Rather, it means to be engrafted into a living tree, to draw life power from new roots, to find a purpose of life as a member of a new community: "the community of those who are healed."

Is this not exactly how Paul spells out the essence of the church? He depicts it as the body of Christ in which all Christians are active members in executing

God's salvation in this world. It was an African preacher who made this concept plain to his congregation saying:

"Jesus Christ has no feet to go to the people — save our feet, by which our congregation goes to meet them.
Jesus Christ has no hands to help the people — save our hands which we clasp for prayer and join for action.
Jesus Christ has no mouth to proclaim the good news of salvation to the people — save our tongues which can tell them what God has done in love to this world.
Jesus Christ has no bank account to pay for his service on earth — save the purses in our pockets, in which is the money that has been entrusted to us.
Jesus Christ has no eyes to see what has to be done now — save our eyes which have been enlightened to understand in the congregation the plan of God at this stage.
Jesus Christ has no body on which one could touch the nail-marks — save our congregation which manifests in its suffering service the coming of the Kingdom of God."

These words explain already that "the community of those who are healed" is not to be understood in a static way as being in possession of health. This concept is rather one of dynamic action, and the one who acts is God Himself. Sure enough, this healing experience has established a relationship of peace between God and His people. However, this peace may be broken, and new healing may become necessary. But the dynamics of life have been set in motion in a positive direction. The fellowship of the new community has been experienced. Whatever may come now, there is healing at hand. One feels tempted in this connection to translate the famous saying of the reformers that man is "simultaneously righteous and a sinner" into African thoughts by using the term "simultaneously healed and in need of healing."

Tensions of a social nature may break this peace. I recall an experience from the time when I was lecturing at the Lutheran Theological College at Mapumulo, Republic of South Africa. During our discussions in a study group, one of the African students suddenly burst out his frustrations against me at the top of his voice. When he had stopped, I heard one of the other African students close to me saying: "Woe, now the peace has been broken! " No further useful discussion developed after this event. In the course of the afternoon, I visited the room of the peace-breaker, and I found him ill in bed. There were no symptoms of any recognizable disease; but his condition was critical. Medical doctors in South Africa usually declare cases of such a kind as "Bantu diseases" which cannot be identified by our scientific methods of diagnosis. Surely also, this student could not be cured by medical treatment in hospital. How would you have reacted in such a situation?

I called for some other students who were present in the morning session, and we talked for a long time with their diseased fellow. More than once I was shocked by the frankness and the sharp words of his fellow students by which they reprimanded him concerning his incorrect behaviour; I would have never dared to do it in that way. Under these damning accusations, the sick student broke down. Finally, one of the other students proposed to pray. One after the other led in prayer, telling God about his brother, interceding for him and requesting for him "life". In conclusion we shook hands. By that time, I had not yet learned so much from the African independent churches and their use of symbols; otherwise, I would have probably shared a cup of cold water with him as a sign of reconciliation. We left the room, and there was no more discussion on the student. However, the next morning he was again fit in class, and the work proceeded smoothly. The peace was restored. The community of these Christian students had experienced healing once more; its wholeness was restored.

I am convinced that the fracture of a bone would never have moved this group of African theology students to such a degree. Things like that just happen, and the damage will be fixed by a medicine man or a medical doctor in the same way as a motor car is sent for repairs to the garage. An accident does not seriously affect one's relationship to his community nor to God. Nevertheless, there are diseases which could be recognized easily by us as caused by germs or bacteria, while Africans would basically disagree with you, declaring firmly that they resulted from sorcery. And sorcery is a very able African expression of the hatred resulting from tensions within the community. It does not improve the scope of our service to declare this deep insight as superstition, merely for the reason that a terminology is used which differs from ours. There is no use in complaining about patients who were discharged as healed from our hospitals, observing that straight from there they went to the "doctor-priest" of the pre-Christian African religion or to the "healer" of an African independent church for further treatment. Obviously, from their different thought structure, they did not experience our medical treatment as "healing"; it was, from their point of view, no more than attention to an ailment: treatment of a symptom rather than of the disease itself. They disagreed from the beginning with our scientific diagnosis and they were disappointed in their expectation to be given a restored fellowship and peace with the community and with God.

To put it in a nutshell: according to African theology, healing is a matter of personal relation-

ship, while we Westerners are used to looking upon it as a technical process. My friends in Africa regard medicines as a means by which the salvation of God is communicated to us, and believe that one can also use water or ashes or sour milk, whereas the Westerner regards the pharmacological ingredients of medicine as effective in themselves, and uses God merely as a stopgap in case of failure.

The issue at stake here is the question: "How can communication be achieved, since the doctor and the patient approach healing from radically different concepts?" Shall we demand of the African in our missionary activities to become European or American as a precondition of admission for baptism? In this era of an awakening black self-consciousness, such a demand would mark the end of Christian mission in Africa. Besides, this method has already been rejected by Paul in the New Testament. Or should medical doctors lock up their scientific books at home when being called to serve in an African church and adapt their practice to the African way of thinking? I am afraid that this would mark the end of what we used to call "medical mission". It is probably too early to suggest at this juncture that the medical doctor in Africa should understand the diseased African and provide him with the type of healing which he expects to receive and which is experienced by him as actual salvation. However, it is necessary already at this stage to formulate clearly the issue, namely, that any kind of medical treatment which is unrelated to the community and to God has no chance of success in African society, even if all the patients are Christians and belong to mission churches.

Judging from the expectations of an African Christian when approaching a medical doctor, our attention is already drawn to another aspect of this "community of those who are healed"; it is a church which expects something. In Christian terminology we would speak of hope. However, this term, which can be used as a cipher, has to be filled with contents. Surely, it is not only the removal of bodily symptoms of disease and the physical well-being that the patient expects from the treatment. Certainly, there is praise for the doctor who liberally administers injections; when the blood gets hot, a pulsating life power is felt! Nevertheless, the African congregation expects essentially more than that: "Is the doctor to whom I entrust myself able to restore peace between me and my community, between me and my God?" Essentially, this is an eschatological hope, pointing to and longing for a harmony which can be expected in perfection only in the resurrection from the dead and in eternal life. However, it is a special type of eschatology, it is realized eschatology. The patient expects to taste something of this future perfection already, here and now, even amidst his daily frustrations and the tediousness of his money-earning working days.

This experience is given to an African congregation in its worship when they are all assured of the presence of God being there. From this trait, we can understand that "waiting and watching" are central terms in the African theology of healing. Indeed, God is implored in vigorous words, in prayers as well as in hymns of intercession, to make haste in coming and sending His divine and mighty healing. But, at the same time, the African congregation knows that it is impossible to force God in a magical way to do our will, and so the determined congregation of interceders willingly joins in the Lord's prayer: "Thy will be done on earth as it is in heaven."
It is therefore necessary to wait for the coming healing and salvation. Nightwatch services are preferably used for intercessions for diseased people; they watch and wait for the Lord "like watchmen watch for the morning" (Psalm 130:6). There are even healing homes run by African independent churches by the name of "Kwa-Linda", i.e., the home of watching.

When the generator is switched off at night in the mission hospitals in Zululand and the electric lights go out, the patients do not complain; but sometimes they ask for a burning candle, since in its light "it is easy to pray and even easy to pass away." This indicates that they are not concerned exclusively with bodily health; rather, they look for peace.

a. Corporate Commitment

The "community of those who are healed" is dynamic in that it cannot keep the experience of healing as a precious possession for itself alone. The church has experienced this healing in its relationship to the world, and this means, in the first instance, on behalf of and in favour to its surroundings. Therefore, the local congregation must find a way to express its corporate commitment in its local setting. Western medical mission workers complain frequently that the local congregation regards the mission hospital as a source of income only and tries by every available means to fill all the existing vacancies with members of this congregation. I understand this complaint very well from the Western point of view. However, I cannot share it, because I understand also the wholistic viewpoint of the African congregation. A medical doctor does, of course, wish to employ a well-qualified nurse, irrespective of where she comes from. But the African congregation sets other priorities: the new fellowship "of those who are healed" also tackles its function in the healing ministry of the church as a corporate task. In such a situation, they probably value the personal contacts made by a girl who cleans the windows while conversing with a patient no less highly than the specialized work of the medical doctor in the operating theatre.

The fact that a remuneration is paid to the hospital employees is conditioned by the Western structure

of our institutions; however, welcome as the pay envelope may be, it is not the decisive point at stake. This becomes obvious from the healing homes of the African independent churches in which another structure prevails. In these institutions, no wages are paid, and in spite of this fact, the entire congregation works in them, and even provides for the upkeep of the patients. Of course, the structure of these healing homes differs from that of the mission hospitals in other respects too. The medical care for the patients plays a subordinate role only, since the main emphasis is put on worship, devotions and prayer; also private counselling is more strongly emphasized than in the mission hospitals where the chaplain communicates his message through loudspeakers to the patients in the wards, and where the visits of the women's prayer league of the congregation is felt by the hospital administration to be troublesome to the daily routine because it disturbs the schedule of work.

b. Thanksgiving

The church in Africa has made a special contribution to the theology of healing by its emphasis on thanksgiving. Is it not a rather prosaic way of giving thanks, and not even understood by us any more as such, when we pray the bill which is mailed to us after being discharged from the hospital? Now, according to the Biblical understanding, thanksgiving is an essential part of wholistic healing. It was the thankful Samaritan only among the ten healed lepers who returned to Jesus and thereby allowed Him to draw him into the stream of life, and to whom Jesus could say: "Your faith has saved you." (Luke 17:19) We have already observed that healing includes not only the restoration of peace with God, but also with the community; therefore, thanksgiving for healing is a communal affair which cannot be enclosed within the four walls of the church building. Rather, it breaks out into the world, since thanksgiving has a missionary function towards the environment like every genuine activity of the church. There are certain Christian communities which accompany a person who has experienced healing back to his home, where a thanksgiving service is conducted. On this occasion, the congregation offers thanksgivings in cash, kind and prayers to God; sometimes a flower, a coin or a dish of water is brought forward, and intercession is made for every member of the family, that all may be converted into a living faith. The aim of this activity is to provide the one who has been healed with a healthy environment for his future daily life. In African independent churches, this service frequently includes the slaughtering of an animal – preferably a sheep (in order to avoid confusion with the veneration of the ancestors, for whom members of the pre-Christian African religion used to sacrifice the head of a cow or a goat) and the sharing of a communal meal by which the peace and the brotherhood of the new congregation is demonstrated.

INVOLVEMENT OF THE CONGREGATION IN PREVENTIVE HEALING

The relationship of healing to God and to the community is also the point of contact at which the Christian congregation can become involved in preventive healing. Obviously, we cannot follow the Western model of a medical nurse who makes home visits and instructs the families in health care, or of instructors who teach better agricultural methods to the local farmers. I once saw an expert in the field of animal husbandry explaining and demonstrating the use of planting and feeding lucerne to a crowd of Zulu farmers in South Africa. At the end of a long and tiring day under the burning heat of the sun in the Tugela valley, one old man who had listened patiently all day stood up and solemnly said these few words: "Let the cattle go on eating grass! " Thereby the answer was given, and the gathering dispersed.

It is important that a start be made from the world view of the Christian congregation in Africa, which is shaped by their understanding of healing in general and the resulting interpretation of relevant Scripture passages in particular. According to this view, full healing can be achieved only within the congregation. This implies, of course, that peace must be preserved within the church, and this desire urges all its members to prevent possible diseases. It is not normal to do this through inoculation or vaccination; several communities within the African independent churches even forbid vaccination as part of their rule of prohibiting medicine, the acceptance of which would be interpreted as a sign of unbelief in the healing hand of God. However, the relationship between peace with God and the community ought to be preserved and, where ethical misconduct or social tensions endanger this peace, the congregation is only too willing to encourage reconciliation.

From the ethical aspect, this results in observing taboos of often rigoristic nature. Prohibitions of smoking and drinking of intoxicating liquor are in themselves already health-promoting and, because of their religious motivation, also effective. In the recent past, African independent churches have integrated hygiene education and agricultural advice wholistically into their worship life, and even into the celebration of their central annual assemblies. Likewise, possibilities of familiarizing congregations with preventive medicine could obviously also be found within the mission churches.

It would certainly be a good starting point for joint action if both medical doctor and African congregation took seriously the first article of Christian faith in the Creeds. The difference between this and the previously rejected approach lies in the fact that this method makes the relationship of preventive healing to the Gospel

quite clear, while the previous one will be regarded as secular instruction from the Westerner who wishes to impose a foreign way of life. Even if subsequent practical steps seem identical, they are not. The Christian way means that the medical doctor has reached the level of understanding of the people involved, and this makes all the difference. Now they can walk together along this path.

AFRICAN THEOLOGICAL CONTRIBUTIONS TO THE UNIVERSAL CHURCH

In the process of taking seriously the African characteristics of the church, one would certainly be misjudging the situation if one isolated the church in Africa from the larger community of the universal church. The distinctive features of the church in Africa do not detract from the universal nature of the church. They only underline the point that the universal church is always manifested in local churches. In its authentic African garb, the church in Africa is at the same time an integral part of the universal church of Jesus Christ which surpasses and crosses all ethnic and racial boundaries. The attempt to deny this fact would mean to degrade it into an ecclesiastical game reserve with a number of African curios, which would put it into the category of a tribal church. Unfortunately, this attempt has been made often enough.

The All Africa Conference of Churches seriously protested against even the use of the term "tribe" at its last general meeting in May 1974 at Lusaka (Zambia). It is essential to note that this Conference, which emphasized so strongly its African heritage and self-consciousness, rediscovered the value of the African churches belonging to the world-wide fellowship of Christianity. Other churches around the world ought, therefore, to listen to the theological contribution coming from the church in Africa: "The healing ministry is not optional, but obligatory in the life of the church. Since healing is by the Holy Spirit through prayer, those endowed with gifts of healing must be given the authority to exercise their appropriate ministry in the life of the church." From this point of view, the African Christian experience of healing has a dynamic impact on the joint witness of Christians from different nations and races. There where a united witness of this kind is given, not only in words, but also by setting a good example of living together in this larger community, it does not fail to have its impact, and this experience of being healed results in conversion to Jesus Christ towards whom all the missionary activity of the church is directed.

The problem discussed so far confronts the medical doctor working in a church institution in Africa with a difficult task, which he/she shares, however, with the theologically or otherwise trained missionary workers. Doctors cannot escape the issue by leaving work and returning home to a place where there will at least be a common base of thinking with the patients. Even if Reverend John Gatu of Kenya applied the term "moratorium", he did not intend to cause all missionary workers from the West to withdraw. Rather, he intended to make their service relevant to the changed situation of the churches in Africa. Stressing the theological contribution of Africa to the universal church, the proposed moratorium is meant to allow for a period of reflection on the genuine way in which the churches of Africa can face the future, as well as on our possible contributions from the churches in the West in the spirit of partnership in obedience. This marks the end of a mission which is ruled and structured by the Western way of life alone.

However, this new era is a challenge to open-minded Christians and, for the sake of a joint witness, doctors, sisters and pastors will continue to be exchanged between Europe and Africa. Those who are called and sent to Africa will no longer go to an institution called a "mission hospital" run by a missionary society according to Western patterns, but they will go to serve an institution of an African Christian church. They will have to acquaint themselves with the way of thinking of these partners in order to make their medical service in cooperation with the wholistic service of this local church an understandable Christian witness for Africa and its people.

GUIDELINES FOR HEALTH PERSONNEL SERVING A CHURCH IN AFRICA

The above deliberations and thoughts led me to formulate some points for discussion which, in my opinion, could serve as guidelines for the health personnel who go to serve a church in Africa:

1. Everyone sent for special service to a region under the jurisdiction of a church in Africa should refrain from taking up duties immediately upon arrival, even if he/she thinks that the urgency of the situation demands activity right away; rather, each person should take ample time to get acquainted with the language and way of thinking of the people belonging to the partner church.
2. The health volunteers should not be forced into a language school; rather, there should be freedom to discuss with the people of the community and, from the needs recognized during the course of these conversations, they should develop their own plan of work and pattern of service according to their particular capabilities and training.
3. The health workers should discuss the objectives resulting from this period of orientation and preparation with the leaders of the church that called them. During the course of these conversations, they must be open to constructive

criticism and correction in order to achieve genuine cooperation with the partner church.

4. The doctors should not isolate themselves as famous specialists, although they were perhaps greeted as such on arrival; rather, they should attempt to integrate themselves into the social and worship life of the partner church.

5. Right from the beginning, the African patients and co-workers should primarily be regarded as partners in dialogue, and the thinking and practice of indigenous African healers and herbalists should be studied sympathetically and with care.

6. In spite of a deep understanding of the African Christian congregation, personal identity should not be lost; rather, from their own talents, all the health workers should aim to assist the development and growth of new concepts in the fertile soil of African ways of thinking.

7. Each person should conceive the schedule of his/her work in such a way that it can realistically be expected that the church in Africa will be able to take over this health service, without looking for another specialist at the end of that person's term. This implies that the aim is to build up an indigenous ministry of health during the course of each term of service.

COOPERATION

In conclusion, a last but surely not unimportant note: it is not a waste of time for a doctor or any intelligent person to consider these issues, even if he/she will never be sent to work in Africa or in any "Third World" country. The problem of cooperation with a partner church and finding a solution through specialized knowledge and deep reflection is not just confined to the white man living on the African continent. It will soon concern us all in this our shrinking world. We have to face this matter, not only because of the necessity to communicate with people who have other thought patterns, but particularly because, as Christians, we know our missionary responsibility is to *six* continents. We know that we can give missionary witness only through joint action, and this goes for medical mission too.

So far, we have imported doctors and nurses from the "Third World", and we have drilled into them our practice of Western health services. Taking seriously our missionary responsibility in Europe and North America, we have to enrich our service to the West by emphasizing community aspects and the individual's relationship to God in these places also. Thereby, healing will gain a universal perspective which belongs inalienably to the Christian message. The entire world is God's mission field; we would be well-advised to give Western countries this true missionary service as a genuine development aid. Adapting a quotation from Reverend John Gatu, we could say: "White Christians too can do more in their countries when they are trained, encouraged, and supported accordingly." In our special area of healing, we expect this support from the experience of the church in Africa.

CHAPTER XII:

FIVE CHALLENGES TO THE CHURCHES IN HEALTH WORK

by Dr John H. Bryant

This paper is adapted from a presentation made by Dr Bryant at a seminar convened by the Board of Vellore Christian Medical College, New York City, in November 1976. It was then published as CONTACT 42, December 1977.

INTRODUCTION

There have been major changes in recent years in how health is understood and provided for in developing countries. The churches have led the way in some of these changes and have been seriously behind in others. The churches often seem unaware of both the major problems that need to be addressed and the relevance and strength of their own resources for doing so.

The purpose of this presentation is to identify a series of health-related challenges that have special meaning for the churches in terms of both their historic commitments to serve the poor and the special resources of the churches.

The Context: Disease, Poverty and Patterns of Health Services

The major diseases that afflict the people of developing countries are familiar. Gastroenteritis and pneumonia, together with malnutrition and neonatal tetanus, are the leading causes of death in children. Parasitic infestations are widespread, and one of these, malaria, continues to take a heavy toll among children. High rates of population growth have a deleterious impact on both national socioeconomic growth and families, contributing to crowding, scarcity of food and limited maternal attention. A sad summary of the burden of disease in the poor countries is that 1/4 to 1/2 of children do not survive beyond age 5, and many who survive those early years are disabled.

Poverty is pervasive in developing countries, contributing to and resulting from ill health. There are 750 million people in poverty: 85 per cent in absolute poverty (annual income of less than US$50); the remainder in relative poverty (more than $50 but less than 1/3 of the national per capita income). Asia carries the greatest burden, containing 3/4 of those in absolute poverty, the majority of whom are in India, Pakistan, Bangladesh and Indonesia. Worldwide, 80 per cent of poverty is rural.[1] The problems of urban poverty should not be overlooked, however, particularly with the massive rural-to-urban migrations that are under way.

As part of widespread poverty, resources for health services are strikingly limited. Governmental budgets allow less than $1 per person per year for health services in much of Asia; in Africa the figure is generally $1 to $4; and in Latin America $10 to $30. For contrast, overall expenditures for health care in the USA are about $600 per capita.[2]

A most sobering statistic is that spending for health services by developing countries has been *decreasing* at an annual rate of about 2 per cent per year over the past 15 years.[3]

Limitations of resources — manpower, facilities, supplies — are intensified by their maldistribution, particularly their concentration in large urban areas. Whereas national ratios of physicians to population are in the range of 1:3,000 to 1:25,000, the figures for rural areas — where 70 to 95 per cent of the populations live — reveal the true nature of the problem: ratios of 1:50,000 are commonplace and 1:500,000 is not unusual.[4] Numbers and distribution of fully qualified nurses generally follow that of physicians. Much of the planning and organization of health services is misdirected through wishful hoping that more physicians and nurses will decide to serve in these areas.

Health services in developing countries are largely provided by government. In Africa and Asia the private sector is small except for church-related programmes which provide from a few per cent to nearly 50 per cent of beds and services. Private practice is predominantly in the large urban centres. In Latin America and parts of the Middle East paragovernmental organizations, such as the social security systems and foundations, provide care for employed populations.

The design and function of health services follow patterns that are similar from continent to continent. Health care activities usually take place in three types of settings. Hospital services usually include major national and regional hospitals with specialty and technical capability for handling complex cases, and smaller district hospitals staffed by one or more physicians. In these smaller institutions, many activities are carried out by nurses and auxiliary personnel. A second setting for care is the network of health centres and health posts or dispensaries, with or without a few beds. These are staffed mainly by nursing, midwifery and auxiliary personnel, which provide care for ambulatory patients and serve as a base for activities in the surrounding communities. The third setting is in the community itself. There has been increasing attention to developing community-based programmes under the direction of resident community health workers who can relate to local people in promoting their interest, understanding and participation, including the use of local resources, in health programmes. The reality of developing countries is that most health care must be provided by paramedical, auxiliary and community health workers supported by professional supervision on a visiting basis.

Certain changes in emphasis have taken place as well, particularly in maternal and child care. There has been increased attention to the prevention and care of malnutrition in small children, family planning and control of infectious diseases. Immunization programmes have been expanding, the highly successful smallpox programme being a leading example. Health planning methods and national capabilities for planning have improved substantially.

These are only a few indications of widespread efforts to improve the quality and extent of health services in the face of the extreme resource constraints. It needs to be understood, however, that such changes have been implemented only to a limited extent. In large parts of the developing world the majority of the people do not have reasonable access to health care. Throughout Asia and Africa only 10-30 per cent of the population are reached by health services. It is unsual for the proportion to reach 40 per cent. In Ethiopia the figure is probably less than 5 per cent. In Thailand the proportion reached is currently about 30 per cent.[5] In Latin America, only 30 per cent of rural populations have access to modern health services.[6] And, of course, local availability of the services does not mean benefit from services.

The dilemma is that vast numbers of people do not benefit from modern knowledge and technology relating to health. Resources are limited, to be sure, but much more is possible with those resources than is being accomplished. Many other resources, particularly those of communities, are not being called upon. There is a richness of ideas and potential for extending effective services to more people that is not being utilized.

What, then, are the areas in which the churches can contribute? What resources of the churches are particularly suited to grappling with health problems and with the obstacles that stand in the way of improving health services for the underserved people of the developing world? I identify five areas that call for special concern and action by the churches, and I offer them as challenges.

Challenges to the Churches

1. SERVE THE POOR

Economic definitions fall short of describing the full meaning of poverty. Per capita income information can hide the reality that even among the poor, some are poorer than others and have greater needs for health care than others.

The poorest are often excluded by social, political and religious values and structures from whatever benefits and opportunities are available even to poor communities. They are lost from sight; difficult to find. A word for the poor in the Indonesian language means "they who are not", the linguistic expression of their exclusion. Those who enter communities to serve the poor generally assume that they need to work through community leaders, but those leaders may be sources of exclusion and exploitation. Assisting the poor out of poverty is more than an economic problem.

Certain distinctions need to be made with respect to the poor and their needs for health care. Many are already sick with a variety of diseases. Some may not yet be ill but are at high risk to become ill (a child born too soon after a preceding sibling is at risk to become malnourished; a mother in her sixth pregnancy is at risk to have complications). Further, those who need care may not seek it because they don't know of their need or because care is too difficult to reach.

These problems afflict the poor, particularly the very poor, more than the well-to-do, but existing arrangements for health care are not structured to lessen the problems. Resources are concentrated in urban hospitals that emphasize specialty and technology-intensive services and caring for those who have access to them; these clearly favour those who are not poor.

The churches have an historic commitment to the poor, but they have also been part of the problem, contributing to the imbalances toward technology-intensive, specialty-oriented, curative services, often adding a fee-for-service component because of their

own financial needs. These aspects of the churches' involvement in health care are not surface associations but have deep roots in the professionalization of church-related health systems.

The challenge to the churches is carried in the Biblical meaning of serving the poor: those who are not cared for and to whose care no prestige is attached.[7] The dilemma for the churches is that serving the poor will require not only working for change in the secular systems of governments and private sectors, but also overriding long-standing orientations of the churches themselves and their health professionals.

2. REDEFINE DEVELOPMENT

Definitions of development in the recent past have centred largely on economic criteria such as per capita gross national product, and development assistance programmes have often been directed toward increasing that measure of development. An underlying assumption has been that benefits of economic development would eventually also benefit the poor. This concept has been shown to be inadequate; the benefits that are experienced by the poor are actually small, or none at all. The benefits remain largely with the most productive sectors where they were invested. Further, there has been widespread resistance to defining human development in terms that are predominantly economic.

Other measures have been used to characterize development, for example, the percentage of school-age children in school, and nutritional measures that take into account both quality and quantity of food.[8] Such figures are helpful in measuring specific aspects of development, but they miss essential qualities that are important to individual and community life.

Alternative definitions of development are needed to reflect the dynamics of community life and social growth. Additionally, communities should be viewed in terms of their local uniqueness and not only as part of some national average. In order for the rural majority to grow in self-reliance, dignity and full participation in its own affairs, human and social development should proceed more rapidly than economic development.

One approach has been to think of development in terms of meeting basic human needs.[9] I follow that approach here by identifying certain minimal services, resources and opportunities that should be available to persons and their communities if basic human needs are to be met:

1. To be protected against preventable diseases (through immunizations, control of vectors, access to appropriate nutrients and to safe water, family planning, health education, etc.); to have access to primary health care and, through that, to more specialized forms of care when they are needed.
2. To have access to at least primary education, and more advanced education according to individual ability if resources are available.
3. To have adequate and safe shelter.
4. To have an income necessary to support a family.
5. To live in a safe environment that retains some of its natural beauty.
6. To have political and religious freedom.
7. To participate in decision making that determines one's future.

Quantitative measures of some of these minima could be included, such as selected mortality and morbidity rates, indicators of access to health services, rates of literacy and access to education, employment and income indicators, and so forth, applicable at local as well as national levels.

Using these minima as indicators of development, it is clear that economically more developed countries and communities are not necessarily more advanced. Loss of environmental beauty and religious and political freedom are examples of deteriorations that can occur as nations develop in economic terms.[10]

But these indicators still fall short of fully expressing the nature of human development. They fail to capture the richness of human life in individual, social and spiritual terms. What insights can the church offer about the dynamics and quality of development, human rights and values, the role of health in national and community development, and the possibility that those who are economically poor can be rich in other aspects of development?

3. PROMOTE SOCIAL JUSTICE

Taking social justice to mean the fair and equitable distribution of services and resources, major injustices in the health sector are widespread nationally and internationally, partly as a consequence of limited resources, but largely due to social, political and professional actions that deprive the poor. At times these actions are taken without any deliberate effort to steer resources away from the poor. A ministry of health, for example, decides to enlarge an urban hospital in order to provide referral services for a regional or national population, but the result is further diversion of resources from the rural population. A church executive does not understand the technical possibilities of reaching the poor and fails to make decisions that will direct resources toward them. A medical school has admission policies that perpetuate the cycle of well-educated parents who provide quality education for their children that gives them competitive advantage in gaining entry into medical school.

Much of the time, of course, there is nothing inadvertent about decisions that lead to injustice; they are made with the clear intent to maintain an existing imbalance between the urban and rural, the rich and the poor, the powerful and the powerless.

The underlying causes of these injustices are deeply imbedded in the social, economic and political structures of society, and attempts to root them out often involve direct confrontation with the power centres of society. One approach to the problem, admittedly a somewhat theoretical one, is to define principles of justice for health care that can be used as guidelines for getting at injustices.[11]

The general principle is:

Health services should be available to all; any imbalance in distribution should be to the advantage of the least well off.

Secondary principles follow:

A minimum of health services should be available for all. What is included here will depend on resources: a network of primary health services including preventive, treatment and environmental programmes would be desirable; where there are more limitations of resources, perhaps only immunizations, health education and protection against selected widespread diseases such as malaria would be possible.

Resources which can provide more than this minimum should be directed toward those most in need (not necessarily those who seek care). Means should be developed for reaching out, searching through populations for those most in need and whose conditions can be helped through health services.

Potential recipients of services should participate in decisions on how health-related resources should be used.

The churches have committed themselves to combat social injustice. They have also contributed to injustice, unknowingly for the most part, through their medical mission and medical education programmes. Can the churches redirect their own programmes so as to promote greater justice? Can the churches be advocates for social justice in governments and other organizations when taking such positions will run up against established orders, both within the churches and in the larger society?

4. DISTRIBUTE HEALTH SERVICES EQUITABLY

Answering this challenge requires the practical implementation of the commitment to social justice. It involves facing the dual problems of limited resources and reaching those most in need of health care. A balanced system is required that includes different levels of health services — hospitals, health centres and community-based programmes — that are fitted to the health problems, environmental conditions and sociocultural aspects of community life.

Building community-based health services can be the most difficult because it requires sharing knowledge, resources and decisions with community people rather than proceeding unilaterally in the name of the health care system. While the resources of the formal part of the health care system — professionals with their expertise, well-trained auxiliaries, material resources, etc. — are necessary, they are of little avail unless joined by community resources — the ideas, commitment of land, crops, money and social organization of local people.

The church is eminently suited to function at this level and has a heritage of serving people as they are and where they are. The question is: can the church balance its involvement with medical schools and hospitals (often with specialty and technological emphasis), to develop community health programmes and to become closely enough involved with communities in order to realize the greater strength that comes from sharing, rather than simply providing, resources?

5. DEVELOP EDUCATIONAL PROGRAMMES FOR HEALTH PERSONNEL THAT LEAD TO COMPETENCE AND COMMITMENT TO SERVE THE POOR

Here is a technical/ethical dilemma that I will address mainly as it applies to medical education. Medical education and health service programmes are needed that encompass technological excellence, including specialty clinical capacity, but the process of establishing such technological excellence has resulted in serious imbalances. There has been overemphasis on specialty training and associated services, and medical students have tended to make career choices that carry them in the same direction, drawn often by the prestige and financial reward which they see coming to their professors and physicians practising in urban settings. One obvious result is that relatively few medical students choose career positions that serve the rural majority of the people and the poor. In this respect, medical education is often socially dysfunctional and misses the mark for the society in its widest sense: vast investments of public funds intended to meet public needs come to naught.

The problem is familiar, and many remedies have been sought. Unfortunately, the usual solutions have had only marginal effects. The development of community outreach programmes by medical schools, the addition of departments of preventive and social medicine, etc., are intended to shape the competencies and interests of students toward working with populations with great needs.

However, the values and attractions of technology-intensive, specialty-oriented hospitals are strong and often make such socially oriented educational methods ineffective.

The important point is that the usual solutions to gaps in socially-oriented values of students follow the same pattern as most "solutions" to curriculum defects, namely to change the content by adding a new course or department. While changing curriculum content might be expected to add to students' knowledge and skills, only a limited effect on their values, attitudes and commitments can be expected. To affect those attitudes calls for entirely different strategies, probably including radical change of the entire educational milieu.[12]

It is very difficult to know how to structure an educational programme that will result in students and graduates being competently trained and committed to serve the poor. Extensive changes in traditional approaches to medical education are required. New educational policies and styles need to be developed. The criteria by which candidates for medical training are selected need to be changed to include an assessment of motivation, expectations and human values. The question is: do the churches have the commitment, understanding and internal strength to work their way through this set of questions?

CONCLUSION

These challenges to the churches — to serve the poor, redefine development to include social as well as economic growth, promote social justice, distribute health services equitably, and develop educational programmes for health personnel that will lead to competence and commitment to serve the poor — carry a certain irony. Each challenge is already part of the historic purpose of the churches, and the churches have already pioneered in these areas. But works that were pioneering in the past are now criticized at times as being self-serving, redundant and even contributory to social injustice. Such criticisms are puzzling and frustrating to those who have followed in the historic path of Christian commitment to serve those in need.

Meeting these challenges under contemporary conditions requires the churches to go on to new ground where there are often new ground rules. Actually, there are already many examples of the churches responding creatively and constructively to these challenges — the Drs Arole in Jamkhed, India; Dr Sibley and his colleagues on Kojedo, Korea; Drs Hendrata and Wardoyo in Central Java; the Medical Mission Sisters in Africa, Asia and now in Tennessee and North Carolina — to name but a few of those who are internationally recognized for their leadership on these modern frontiers. Many other programmes not so well-known as these, are also proving worthy to the challenge in creative, locally relevant and quiet ways.

They are the forerunners in addressing these issues; the challenge to the churches is to support them and those who will join them in their creative explorations while bringing the churches into closer alignment with these advances in serving people in need around the world.

BIBLIOGRAPHY

1. World Bank, *Health.* Sector Policy Paper. Washington, DC, March 1975.
2. Ibid.
3. Sivard, Ruth Leger. *World Military and Social Expenditures, 1974.* New York, Institute for World Order, 1974.
4. Bryant, John. *Health and the Developing World.* Cornell University Press, Ithaca, 1970.
5. Personal Communications, Ministry of Health, Thailand, 1977.
6. PAHO Official Doc. No. 118. *Ten Year Plan for the Americas.* Published by Pan American Sanitary Bureau, Washington, DC, January 1973.
7. Bryant, John and Jenkins, David. *Moral Issues and Health Care.* Proceedings of the Annual Meeting of the Christian Medical Commission, World Council of Churches, Geneva, July 1970.
8. Harbison, Frederick. *Human Resources as the Wealth of Nations.* Oxford University Press, New York, 1973.
9. *Employment, Growth and Basic Needs: A One-World Problem.* Report of the Director-General of the International Labour Office, Geneva, Switzerland, 1976.
10. Bryant, John. "Health as an Entering Wedge of Development". Seminar, Johns Hopkins University. Baltimore, Maryland, January 1976.
11. Bryant, John. "Principles of Social Justice as a Basis for Conceptualizing a Health Care System". *International Journal of Health Services,* Volume 7, November 4, 1977.
12. Bryant, John. "Problems of Planning America's Contributions to Medical Education in Less Developed Countries". *Medical Education and the Contemporary World.* University of Illinois College of Medicine Bicentennial Symposium. Published by Fogarty International Center, 1977.

THE LIFE AND WITNESS OF THE HANDICAPPED IN THE CHRISTIAN COMMUNITY

INTRODUCTION

The Fifth Assembly of the World Council of Churches in Nairobi in 1975 declared in one of its official reports under the heading of "The Handicapped* and the Wholeness of the Family of God," that:

"The Church's unity includes both the 'disabled' and the 'able'. A Church which seeks to be truly united within itself and to move towards unity with others must be open to all; yet able-bodied church members, both by their attitudes and by their emphasis on activism, marginalize and often exclude those with mental or physical disabilities. The disabled are treated as the weak to be served, rather than as fully-committed, integral members of the Body of Christ and the human family; the specific contribution which they have to give is ignored. This is the more serious because disability — a world-wide problem — is increasing. Accidents and illness leave adults and children disabled; many more are emotionally handicapped by the pressures of social change and urban living; genetic disorders and famine leave millions of children physically or mentally impaired. The Church cannot exemplify 'the full humanity revealed in Christ', bear witness to the interdependence of humankind, or achieve unity in diversity if it continues to acquiesce in the social isolation of disabled persons and to deny them full participation in its life. The unity of the family of God is handicapped where these brothers and sisters are treated as objects of condescending charity. It is broken where they are left out. How can the love of Christ create in us the will to discern and to work forcefully against the causes which distort and cripple the lives of so many of our fellow human beings? How can the Church be open to the witness which Christ extends through them?"

This declaration provided the background for a consultation held in Bad Saarow, German Democratic Republic, 3-7 April 1978, on the theme, "The Life and Witness of the Handicapped in the Christian Community". This meeting was sponsored jointly by the Innere Mission und Hilfswerk of the Evangelical Churches of the GDR and the World Council of Churches (Commission on Faith and Order; Commission on Inter-Church Aid, Refugee and World Service; and the Christian Medical Commission). Thirty-eight participants from fifteen countries met in this consultation. Most of them were people directly engaged in the work with the disabled; some were themselves physically handicapped.

The following abbreviated report of the consultation contains the insights, experiences and recommendations of the participants:

I. 1. **We commit ourselves to the conviction that full acceptance of persons with handicaps within the life, witness and service of the church is a requirement for the wholeness of the family of God.** We view this consultation as a contribution to the task of demonstrating and furthering the unity of God's family by what we do together as disabled and able-bodied.

2. **The wholeness of the family of God on which Nairobi laid such emphasis implies the full acceptance of the disabled in the life, witness and service of the church.** This full and unconditional acceptance of the handicapped must be made a reality at the very heart of the church's life.

---

* It should be noted that the terms 'handicapped' and 'disabled', 'handicap' and 'disability' can be used interchangeably.

3. **When we confess our belief in the complete oneness of all human beings in the family of God, we are clearly affirming that no one may be excluded or excepted from it, however severely handicapped.** No physical, mental or sensory disability may be made a pretext for denying this solidarity. There is no Christian community without the disabled. When the handicapped are missing, the community itself becomes handicapped.

4. **Our Lord Jesus Christ identifies Himself with the handicapped. In them, He encounters the community, just as He discloses Himself to us in all those who are outcast, all who suffer, all who are despised.** The Christian community is constantly summoned to gather together around its Lord. It is the permanent task of the Christian family to gather and to integrate all the members of His body. It is right to speak, therefore, of a constant mutual integration of the disabled and the able-bodied.

5. **The consequences for the life of the church are evident, in both worship and service, and affect the ordained as well as the lay leadership.** Starting from the assumption that the presence and participation of the disabled is the normal case and not the exception, we ask for forms of worship which are appropriate to the ways in which disabled people can express themselves. We doubt most strongly that there are reasons to prevent baptized disabled persons, regardless of the kind of disability, from the Lord's table. Equally strongly, we must assure the accessibility of disabled people to the ordained ministry.

6. **The unity of all human beings, irrespective of their handicaps, is a sign of the preservation of the world from inhumanity. The presence of the disabled reminds us that every human being is a frail and threatened being and a being created and blessed by God.** When those who are able-bodied remove their disabled fellow human beings to a ghetto-like existence in homes or institutions, or abandon them to isolation and loneliness in their own homes, all are in danger of losing the opportunity of partnership and the full richness of human experience.

7. **Fellowship between the disabled and the able-bodied makes it easier for all to be realistic and honest in admitting that no life is exempt from handicaps of some sort.** A sharp distinction between the "handicapped" and the "healthy" prevents the recognition that every human being, at some time — or many times — in the course of life, if only in old age, must contend with disability.

II. 1. **In thus affirming our conviction that the unity and integration of the disabled in the church are based on the Gospel of Christ, we affirm also the continuing need for institutions in which the most severely disabled experience help, protection and care.** We acknowledge with gratitude the help and the home which such places provide for thousands of disabled human beings, and that in these institutions new and improved therapeutic methods, technical aids and nursing systems have been developed which have become an indispensable aspect of the work with the disabled today.

2. **Action for prevention of disability is a critical demand not only for secular governments but also for the church.** We urgently request ecumenical organizations, churches and development agencies to include the *prevention* of disability among their priorities for intensive and wide-ranging effort. In many countries of the world, disability prevention efforts are completely lacking or only at a very rudimentary stage. According to estimates made by the World Health Organization and other organizations, 10 per cent of the world's population is disabled (i.e., 400 million human beings). It is also estimated that more than half of these disabilities could be prevented by overall preventive measures. If the number of disabled people is to be reduced, in Third World countries especially, among the most important steps required are: adequate and balanced diet, health care among mothers and small children, inoculation programmes, sanitary measures, safe and available water, education in hygiene. Therefore, the emphasis must be on preventive measures.

3. **We are convinced that, in cooperation with government bodies and voluntary welfare organizations, the churches must develop comprehensive patterns of preventive rehabilitation as a matter of urgency.** The people in the villages and towns can help here in more ways than is sometimes expected of them. Within these overall patterns, the specialist institutions, clinics and rehabilitation centres can also find an important and even financially viable role. In many cases this will entail a radical shift in the direction of their work and a reallocation of funds and resources.

4. **With regard to the situation in Europe, we wish to draw attention to the need to continue supporting the services of the**

churches with and for the disabled in institutions and rehabilitation centres. The whole church owes its members in these institutions the continuing ministry of intercession. Among the responsibilities of the churches is to help to provide sufficient personnel for this vital and difficult work, to offer training and retraining, and to facilitate an ongoing exchange of information and experience. A constant effort must also be made to ensure improved living conditions in institutions as well as improved conditions of therapy and work. Section 9 of the United Nations "Declaration of the Rights of the Handicapped" states: "When a handicapped person is unavoidably placed in a specialized institution, the environment and living conditions should as far as possible be comparable with those of a person of similar age living a normal life." This would suggest, for example, that the creation of hostel-type accommodations and residential homes for mentally and physically handicapped young people is needed, preferably together with able-bodied young people.

III. 1. **But the church must go beyond the institutional response and move to a dramatic affirmation of congregational acceptance of the handicapped within the mainstream of congregational life.** The criterion of life in the Christian community must be whether or not the disabled really share fully in that life. The church loses its credibility when its proclamation of the unity of all Christians is not matched by a shared life in the fellowship of the Christian community. But the task of mutual and continuous integration of the handicapped into the life of the church implies the destruction of many barriers to achieve that goal.

2. **The greatest barrier is found in prejudices and attitudes.** To a large extent, disabled people are emotionally rejected people. Other people do not quite know how to deal with them. They shy away from them, in a reaction of horror or fear. The ideal figure of the young, athletic, fully productive human being leads them to disparage the handicapped person as a second-class human being. The Christian community must, therefore, be or become the place where these prejudices and attitudes are uncovered and changed by a human ideal which takes its direction from Jesus Christ as the suffering servant of God and the brother of the poor and despised.

3. **The barrier of pity is particularly discriminating to disabled people.** When anyone commiserates with a disabled person as an "unfortunate" pitiable human being, this immediately creates a gulf between them. A condescending pity springs from a sense of superiority or fear, and reinforces feelings of inferiority in the disabled person. Apart from the fact that pity tends to evaporate fairly rapidly, it also establishes a pattern of paternalistic aid and thus results in a relationship of dependency which the disabled person rightly rebels against. But in the Christian community, all belong together as equally respected persons, irrespective of the degree of disability.

4. **The barriers set up by forms of worship and liturgy must be broken down.** The services must be so designed that the disabled can participate. In this respect each liturgical tradition will have to ask itself different questions. But in each case the communal character of worship needs to be more strongly focused.

5. **The architectural barriers must be removed.** We urge church authorities and congregational councils to ensure that the house and the altar of God are made accessible to the disabled as well as the able-bodied. Churches and church premises should be so designed that handicapped people can feel at home in them.

6. **Congregations should consider taking a stance of advocacy for and with the handicapped.** Congregations which seriously try to overcome their own barriers can also become credible champions of the handicapped. As partners, church and handicapped may present their common needs to the general public in the local communities and elsewhere.

7. **Overcoming the sense of isolation of the handicapped is a particular responsibility of the church.** One particularly important task is the regular visitation of the disabled and their parents, spouses, and relatives, and sharing in their struggle against loneliness and embitterment and with day-to-day difficulties. Members of the family need regular periods of relief from the nursing of their disabled member (for example, by home helps). Parishes should also consider arranging joint holidays, outings and excursions.

8. **Sensitivity to the situation of disabled fellow human beings must be developed in the**

teaching and catechetical work of congregations. This training in sensitivity must begin in the kindergarten and continue in the Sunday school and in other teaching activities.

9. **The majority of Christians and society generally tend to regard the search for partnership and the sexual needs of disabled persons with incomprehension and rejection.** We must, therefore, make it a rule for ourselves, and ask the churches to do the same, to react with a wholistic ethical response, and not with a moralistic or legalistic bias, when handicapped persons seek novel solutions which may perhaps appear shocking to us. We must put ourselves in the place of the disabled person and ask ourselves what expression is open to, and would be a responsible one for, him or her of the disposition which God has given to us all.

10. **Like their peers, young disabled persons especially strive for independence and autonomy.** Our question therefore is: can congregations help to ensure that residential homes are built in which physically and mentally disabled young people can share life with able-bodied young people as independently as possible?

11. **We frequently note that pastors, priests and church workers have an inadequate understanding of the disabled person and his or her situation.** There is a striking gap here in theological training. Therefore, we call upon the churches to study, in depth, the theological and ecclesiastical understanding of the church in reference to the handicapped, to emphasize the Pauline insistence on God's expressing His strength and weakness, and of Jesus' insistence upon the inclusion of "the poor, the maimed, the blind in the great feast of the Kingdom."

IV. What should be the next steps?

We are grateful for the cooperation between a number of sub-units of the World Council of Churches and the Innere Mission und Hilfswerk of the Evangelical Churches in the German Democratic Republic which made this consultation possible. We regard the consultation as the first of many such ecumenical initiatives. Among the *future tasks and requirements* are:

1. Action which can be started by all churches:
   - Ecumenical exchange of experience and results of research, with the participation of disabled persons, and including the Roman Catholic Church;
   - Support of minority churches in their work with the disabled;
   - More thorough study of disability prevention, in close cooperation with other international organizations such as the World Health Organization and Rehabilitation International.

2. Specialist conferences should study the following problems:
   - Opportunities and models for the integration of disabled persons in the life of the churches;
   - Partnership and sexuality among disabled people, and counselling methods;
   - Religious instruction of mentally disabled children and adults; provision of ecumenical curricula and materials; the development and diffusion of new forms of worship which do justice to disabled persons.

CHAPTER XIV:

RELATIONSHIPS — THE THIRD DIMENSION OF MEDICINE

The following paper is based on informal remarks made by Dr Paul Tournier to the staff of the Ecumenical Centre, Geneva, at the invitation of the Christian Medical Commission, on 29 June 1978. It was then published in CONTACT 47, October 1978.

To begin with, I wish to thank you for welcoming me so warmly. I have read the publications of the Christian Medical Commission with great admiration. Your horizons are very broad. I perceive an interesting contrast, however, between your work and my own. The CMC is open to the whole world, while I am a man of intimacy. The experience I have to bring to you is from the intimacy of a fireside where people share their confidences.

As a Christian, I have always tried to interject my faith into the practice of my profession. But it was not until I reached middle age, around 40, that I really found my path. It was then that my books began to be published and many colleagues told me that they too would like to combine their Christian convictions with their medical practice in some way. This is not an easy combination. We speak of faith in religious gatherings, but then we practise medicine as we've been taught it in medical school.

Last year, I was lecturing in Japan. After a conference in Kyoto, chaired by a professor of psychiatry from Kyoto, we went to visit some Buddhist temples and I had an opportunity to talk with Dr Kuma of Kobe. He told me that his father had been a famous doctor, so he had had to work very hard to build up a reputation of his own. Finally, he succeeded, opened his own large clinic and then, ten years ago, told himself that he'd made it. But he began to feel anxiety, as if his life's adventure was over and he was in a rut. At the advice of a colleague, Dr Kuma visited the Jung Institute in Zurich where a new adventure began with his discovery of what he calls the "second dimension of medicine". He realized that there is a psychosomatic side to all the illnesses his patients were telling him about. Later, the same colleague suggested to Dr Kuma that he read some of the things Paul Tournier had written. So he read all my books which had been published in Japan and discovered that medicine has a third dimension.

This Japanese psychiatrist did not thereby become a Buddhist priest. But he realized that not only is there a physical and psychological side to every patient, but also a spiritual side. (Dr Kuma saw the close reciprocal relationship between the body and the soul and between physical medicine in the classical sense and the problem of religious belief.) I was delighted to hear this Japanese colleague speaking about the three dimensions of medicine.

"... MEDICINE OF THE WHOLE PERSON ..."

But what is this third dimension? My friend, Dr Lindeboom, of the Free University of Amsterdam, which is a Christian institution, has suggested that, instead of talking about the "medicine of the whole person", we speak of "spiritual psychosomatic medicine". The word "psychosomatic" was introduced to identify illnesses which stem from psychological factors. It is true that I am very much concerned with the influence of a person's spiritual life on illness. But I had serious objections to Dr Lindeboom's suggestion, which he completely accepted, because I do not believe we can speak of three parts of man. It's unfortunate enough that we have separated the body and soul. But things become even worse if we put the spirit in opposition to the body and the soul and then ask that these three things be brought together. Instead of breaking man down into three fragments, we should try to find a meaning for the *whole*. Medicine has become very specialized, and to study and combine all the specializations is only a dream. You can be a cardiologist, a rheumatologist, a psychologist, all rolled up in one, but you still won't have the whole picture. It is this sense of the *whole* which medicine has almost lost, and it is the price of the great progress made by technological, analytical medicine. Psychosomatic medicine remains a purely scientific discipline; it is objective and this kind of doctor is concerned with analyzing the relationship between the soul and body and what separates the two.

"THE THIRD DIMENSION OF MEDICINE – THE SPIRITUAL DIMENSION – IS ONE OF RELATIONSHIPS."

To get the whole picture of a person, a doctor must enter into a personal relationship with him as a whole being. Thus, the third dimension of medicine – the spiritual dimension – is one of relationship. What is spiritual in us is our need for relationships: with our neighbour, with nature, with society and with God. This, I think, is the broadest definition of spiritual life. It is what makes us a real person; not our body or our psyche or something else. Professor Siebeck from Heidelberg has defined it as *interpellation,* whereby man is called upon by God to account for himself and this is what makes him feel like a person in God's sight.

"BY MY PERSONAL RELATIONSHIP TO MY NEIGHBOUR, I ALSO FEEL MYSELF TO BE A PERSON."

I have always tried to establish such personal relationships with my patients. We can discuss many things objectively: science or politics or economics. You run no personal risk that way. But until you talk to someone about your personal life, you don't get really involved. There is something reciprocal about a personal relationship.

According to Martin Buber, the Jewish philosopher, two kinds of relationships are possible: *I* and *That,* and *I* and *Thou.* In the first, *I* is the observer of an object. This is the position of science and of scientific medicine, which studies man as an object, making of this object a *thing.* Then it is very difficult to see the *person* in a patient. Everything about him is an object to be observed: his anatomy, his physiology, his psychology, perhaps even his spiritual life which is regarded as a form of philosophy. But Martin Buber speaks of the second kind of relationship, the one of *I – Thou.* It is no longer a subject-object relationship, but subject-to-subject. This is a personal relationship. To achieve it, a physician must abandon his scientific attitude to some degree. In today's civilization, we live in a world of *things.*

I'm reading a little book entitled "Psychotherapeutic Dynamics of African Bewitched Patients" by a Zaïre theologian, Ma Mpolo Masamba, who is now Director of the Department of Family Ministries of the World Council of Churches and who was kind enough to dedicate the French edition to me. In it, there is a remarkable sentence: "You Western doctors treat *things* and our African medicine treats *people.*" He has asked himself the same question I do and he realizes that a doctor must learn to open himself up. Ours is a technological civilization and we have become accustomed to seeing everything objectively. I am afraid there is a dialogue of the deaf in the developing countries between the Western-oriented people on one hand, who are interested in *things* – that is, in all the objective phenomena which Western medicine studies – and the indigenous people on the other hand, who are interested in *persons.* The Westerner wants to explain that the causal relationship is an objective one, while the indigenous person sees relationships and the mystic meaning inherent in them. In the West, a sick person is taken away from his family and put into a hospital where he is shifted from one machine to another in a world of things, of apparatuses. Traditionally, medicine in the developing countries cares for the sick person within his own tribe; it treats his interpersonal relationships and, as I have learned from Dr Masamba's book, it tries to help him solve whatever problems he may have with his family or his neighbours. These are two totally different perspectives: the mechanical one which is concerned only with immediate, objective *things,* and the spiritual, which sees relationships between people. It is not easy to shift from an objective attitude to a subjective one. For over thirty years, I have been meeting with doctors who have been trying to make this shift. They are known as the Bossey Group, after the Bossey Ecumenical Institute* where we originally met because of my friendship with Dr Visser t'Hooft, (first General Secretary of the World Council of Churches: editor's note). The Bossey Group tries to advance the idea of *medicine of the person,* of studying man as a whole.

"IF DOCTORS WANT TO ESTABLISH A PERSONAL RELATIONSHIP, THERE MUST BE A CHANGE WITHIN THEMSELVES."

Doctors like to talk, you know. They could talk about Man in a very scholarly vein for years and years. They could talk about the anatomy of the brain, about Jung's psychology and so on – all very nice and very interesting. But nothing happens to the doctors themselves as long as they only talk. If they want to establish a personal relationship, there must be a change within themselves. Discussion changes nothing. It is simply an intellectual exercise, and the intellect still belongs to the realm of *things.* Doctors must, therefore, do more than just have discussions. They must have a personal experience of a personal relationship. That is why we always agreed in the Bossey Group that we would discuss our medical work during the day but, in the evenings, we would talk about personal matters:

---

* The Ecumenical Institute, situated on the shores of Lake Geneva, between Geneva and Lausanne, is an integral part of the World Council of Churches. Its principal aims and functions are to provide training for future ecumenical leaders, both clergy and lay, to promote ecumenical theology and to practise ecumenical education.

why we became doctors, for instance. When were we ill ourselves? What are our problems, our doubts, our failures, our regrets? What conflicts do we have with our wives or children? Doctors know that if they go to a meeting of the Bossey Group, they will be expected to talk about their personal life. There are many doctors who have never even dared to come because they have been too frightened. This shows how a doctor hides behind objective attitudes which allow him to maintain a scientific front while leaving his personal problems in the shadow. For years, I have been able to observe many famous doctors who, although they may lecture all over the world, when alone with others in a private room, find themselves face to face with a blank sheet, at a loss for words. Our whole upbringing and schooling ever since kindergarten, has trained us to be objective. We find it very difficult and are afraid of being subjective and personal. I certainly do. I'm terribly shy. Maybe that's why I can understand how difficult it is. This is where the third dimension of medicine plays a role: when we give ourselves to other people, or to another person.

I no longer direct the Bossey Group, now that I am an old man. Younger colleagues have taken over who are more daring than I. At the last meeting of the Group, which was held in Austria, it was decided to have no more lectures and professional discussions, but to speak on a personal level not only in the evenings, but all day long, in order to really grow close to each other. That took a lot of courage. But the meeting was a great success and everybody said they'd never had such an experience. No lectures, no discussions, nothing. Just Bible studies and sharing and reciprocal opening up. (The Bossey Group has always tried to emphasize the problem of the personal relationship between doctor and patient as well as all the other problems of our relationships with our neighbours, with nature, and with God.)

"... THE PROBLEM OF MEANING ..."

Then there is the problem of *meaning:* the meaning of life, the meaning of death, the meaning of sickness, the meaning of health, of healing, the meaning of one's personal life. These are problems science cannot solve. The only answer science gives is chance or hazard. Nobel Prize-winner Jacques Monod has said that for science, only chance and necessity exist: the necessity of natural laws and the chance of variations which contribute something new from time to time. Hazard is the god which men of science worship. That is why Lecomte du Noüy, who worked in the USA for a long time, called God "anti-hazard". It is our relationship with God that gives a meaning to everything. If there is no God, then nothing has any meaning. The image of a rolling wheel is the scientific vision of the world: a collection of phenomena which keep going round and round indefinitely along a trajectory of chance.

"SPIRITUALITY MEANS LOOKING FOR RELATIONSHIPS AND RECOGNIZING THAT IT IS OUR RELATIONSHIP TO GOD WHICH GIVES MEANING TO NATURE."

Everybody is preoccupied by the problem of meaning. When someone gets sick, the first thing he asks is: "What did I ever do to God that He has made me ill like this? " This person doesn't believe either in God or the Devil. But the first idea that comes to mind when he gets sick is that it is a punishment from God, since everybody asks himself questions about the meaning of things. Has it a meaning, we wonder, this illness that has befallen us? It is precisely the objective, scientific viewpoint which denies any meaning. People with this outlook will tell you that an illness is only accidental. But man has an intuition which tells him it isn't really accidental, that we are more or less responsible for ourselves and that this feeling of responsibility is what gives meaning to our lives. One very famous psychologist is stressing this at the moment. His name is Viktor Frankl, and he occupies the chair at the University of Vienna once held by Sigmund Freud. Frankl says that, at the time of his illustrious predecessor, sexual repression was the malady of the epoch. But the world has changed a lot since Freud's day. This kind of repression is no longer such a problem. Sexuality is being expressed very well indeed. But we have repressed other things. Now, Frankl, says, we have repressed meaning. We pretend to ignore the question of the meaning of our existence. And yet, everyone asks himself the same question. It preoccupied Camus, you know, as he retold the legend of Sisyphus, the Greek hero who had to keep rolling a huge boulder up a hill and each time he got it to the top, it would slip back again. Is this what life is: simply an immense perpetual effort which leads nowhere? Only faith can give us the vision of a goal, a meaning to life, and a meaning to illness, to infirmity and to death.

There was a German scholar among our Bossey Group, Dr Jores. When he was appointed Rector of the University of Hamburg some years ago, he spoke in his acceptance speech about the meaning of illness. Making such a speech in this very academic setting was like dropping a bomb. All of a sudden, somebody was saying something that was not at all objective, posing a question of conscience. Dr Jores had the courage to say that the more one reflects, the more one can see a meaning, and God's intention. He also spoke of the Biblical idea of the Fall and said that man's illness is a sign that he has fallen away from God's order. Frankl sees this as the problem of modern man: that he doesn't know why

he exists and wonders whether all his efforts will amount to anything or not. Frankl speaks of an existential void.

Existentialism is really about our relationship to others which is, in fact, a malady of our times: the fact that millions of people, especially in the Western world, no longer know why they exist. Which is enough to make anybody sick. Certainly many ill people express their despair through their illness. I have been reading a report by the president of the society of Swiss psychoanalysts, who happens to be a neighbour of mine. The report is about the meaning of despair. We live in a world of despair, which is related to the whole problem of meaning. Frankl, for instance, says that people no longer blush about sexuality. They blush about religion.

"THE THIRD DIMENSION OF MEDICINE IS TO HELP OUR PATIENTS BECOME PERSONS, TO BECOME AWARE OF THEIR RESPONSIBILITY FOR THEMSELVES."

Thus, the third dimension of medicine is to help our patients become *persons,* to become aware of their responsibility for themselves. In purely technical medicine, they surrender their responsibility for their lives into the hands of doctors. In three-dimensional medicine, they become responsible for themselves again and everything regains a meaning. In other words, we ask ourselves what God is saying to us through illness.

Once I asked the doctors in the Bossey Group to tell of some of their experiences when they themselves were ill. It is always very interesting to listen to doctors talk about their own experience in this domain, because they have just as many personal problems as do their patients. And, finally, there is always the problem of death.

"... WHEN DEATH IS NEAR, THE PROBLEM OF RELATIONSHIPS REALLY PRESENTS ITSELF. THIS IS WHEN THERE IS A NEED FOR A PERSONAL RELATIONSHIP BETWEEN THE PATIENT AND THE DOCTOR ..."

Doctors have a complex about death. Their vocation is to keep death at bay and, when that is no longer possible, they feel a terrible anxiety. One of my colleagues told me that when he makes his rounds at the hospital, he asks the nurse for a report rather than going into a room to see a dying patient himself because he can't stand to be alone, face to face with someone for whom he can do nothing more. Of course, this is when medicine has only two worldly dimensions. Yet this is the moment, when death is near, that the problem of relationships and of the meaning of life really presents itself. This is when there is a need for a personal relationship between the patient and the doctor, and for the doctor to accompany his patient right to the end. This is spiritual love.

Dr Tournier now said that he would welcome questions. The following are some highlights from the question and answer period:

"WHAT SOCIETY NEEDS MOST IS TO FIND A SENSE OF COMMUNITY AGAIN."

Q. You have mentioned that, in Africa, it is the whole person who is treated, that he is not looked at as a thing. But there is still a strong sense of community in Africa which we do not have. How would yout insert this third dimension of medicine in Western industrialized society?

A. Our modern Western society is the fruit of a purely objective, unilateral and technological civilization, and the absence of personal relationships is the sickness of this civilization. If we are unable to establish personal relationships with our wives and our patients, we cannot have them with our society. But what society needs most is to find a sense of community again. All around us we can see little communities which keep springing up, not large administrative organizations like the churches, but small groups of people in personal relationship with each other. The charismatic movement is based on this. These little communities are somewhat fragile, perhaps, but they all demonstrate the need of our society, and especially of young people, to retrieve the sense of community which is missing in our technological society.

"IN THE PAST, PEOPLE WERE BORN INTO A FAMILY AND DIED AMONG THE FAMILY. NOWADAYS, WE ARE BORN INTO A WORLD OF THINGS AND WE DIE AMIDST A WORLD OF THINGS."

Q. In the past, most people had what now seems like a luxury — the possibility of dying at home, among the members of their family. Now, at the critical moment when death approaches, they are whisked off to hospital. This is an impoverishment, both for the family and for the person who is dying. What do you think, Dr Tournier?

A. In the past, people were born into a family and died among the family. Nowadays, we are born into a world of things and we die amidst a world of things. I think this is very unfortunate. It is a sign that we do not attach enough importance to relationships. I lost my wife four years ago. We were in Athens, where I was lecturing to an American group, and she had a heart attack. She spent one month in a hospital under intensive care. It was necessary technical medicine. You can't provide

intensive care at home. So she spent this time in the hospital. But, fortunately, one day she was well enough to be discharged. She still wasn't allowed to take the plane to Geneva, so she came back to the hotel with me and we spent the last three days of her life together, without separating. We talked a bit, we were silent a lot and we prayed together, and we spoke about her death just ten minutes before she died. I was happy that she'd left the hospital, even though I'd gone to visit her every day. She died there with me. Knowing that she was dying, she had been able to express her fear of death, which is a normal fear that people should be able to express, and also having been able to express her hope of resurrection, which she did in a very touching way. She said that if she had died a month before, she would already be in heaven and "I would be able to meet your parents, whom I never met." She had always been conscious of having married an orphan whose parents she'd never known, and it would be in heaven that she would meet them. I answered her quite naturally: "Well, when you get to heaven, my parents will thank you for having been the wife you have been for their son." Those were the last words I spoke to my wife. Five minutes later, she was dead.

(Long pause). You see, no one dares ask questions anymore, because I got a bit personal. You can feel it very well – there is a certain uneasiness as soon as someone becomes personal. It upsets our handling of ideas. But we must reintroduce personal relationships and feelings into this impersonal world. We must bring personal relationships back into the hospitals and into doctors' offices, into living rooms and kitchens.

"IN OUR PROUD CIVILIZATION, DEATH IS LIKE A SLAP IN THE FACE."

Q. The one thing that's inevitable in life is death, but it's a difficult subject for many of us to talk about. People don't say very much in church about it. Why do we, as Christians who believe in the resurrection, find it so difficult to talk about death?

A. I'm convinced that it's quite natural, the anxiety people feel about the idea of death. In the developing countries, death is much more omnipresent. All the sociologists tell us this. Those who are gone are still just as much a part of their tribe as those who are still living. All kinds of ceremonies and celebrations reunite the people of the tribe with their ancestors. This is a much healthier situation than ours, from the psychological standpoint. They accept death as something natural. We in the West are very proud of our technological achievements. Yet even the greatest technological developments cannot eliminate death. So our civilization hides death. The doctor says he wants to comfort the patient, but who comforts, the patient or the doctor? We comfort more than we should to ease our own anxieties. In our proud civilization, death is like a slap in the face. It is a civilization which has tried to forget the divine limits of the human life. How far can we get with our technological progress – to the moon, to creating artificial heredity? In this is a dream of omnipotence. We challenge God and we live within this challenge, and medicine is closely linked with this vain, scientific civilization. So there is great anxiety when the doctor finds himself powerless in the face of death.

Q. Don't you think our Protestant custom of having eliminated the funeral wake is wrong? Don't you think it would be better for people, psychologically and emotionally, to have it? In the south of Spain, I was able to participate in a wake when all the family, neighbours and friends stayed up all night and wept and were together in the presence of the dead person. By contrast, I have a friend in Geneva who is 59 years old and has never seen a dead person. She has begged me, when her husband dies, to come and close his eyes because she doesn't think she could do it.

A. Have you read Dr Raymond Moody's book "Life after Life"? He interviewed people who had been clinically dead and returned to life after various medical interventions. Naturally, they had not really gone *beyond,* because these are people who have returned to life. But they did take the first step into the life beyond. During the minutes that follow death, it is very striking to notice that there is a consciousness that remains after clinical death. All witnesses agree on this point. These people who were dead in the eyes of the doctor have said that, during this time, they had the impression of floating on the ceiling. They could see the doctors and nurses bent over their body and they heard the doctor say, "He's dead", and what the nurses said. So, consciousness persists beyond death, even before the door to beyond opens. This brings me back to the question about death wakes. I had not yet read Moody when my wife died; but after having read the book, I had the impression that she must have been conscious of my first gestures when I phoned a colleague to tell him that she had died. Surely she heard this. So there is a transition between life and what is beyond. We cannot follow them any further, but there is a certain lag between the two. I think the tradition of having funeral wakes is a sacred thing. In any case, I hope I won't die in a hospital, but at home, among my family, and will know that people know that I know that they know and so on...

"... THE DOCTOR SHOULD UNDERSTAND THE IMPORTANCE OF GROWING MORE OPEN AND ACCESSIBLE AND CREATIVE IN PERSONAL RELATIONSHIPS."

Q. In view of what you have said about personal

relationships and from the Bossey discussions, what about the material conditions of doctors? Must they be transformed: the hospitals, for instance, doctors' offices, so that these relationships may be established more easily?

A. I think there's a relationship between the two. The first is the personal development of the doctor himself; that he understands the importance of growing more open and accessible and creative in personal relationships. We can see that doctors who have had an experience of this kind no longer work in the same way in hospitals and elsewhere. There is a certain contagiousness of the personal spirit. But this also has to have tangible repercussions in the organization of material things, as you say. I have seen a doctor leave an important position in a hospital to go to a much smaller clinic where people were able to be closer to one another. This is a matter of one's particular calling. I realize that introducing more personal relationships into the organization of our modern Western hospitals is a very difficult task. We are still at the experimental stage and not at the level of technological perfection so we can't suggest a solution. But we need the specific experience of doctors who realize that medicine is much more profound if we are concerned with the medicine of the whole person, the totality of medicine.

"GOD IS ALWAYS FOR HEALING ..."

Q. It's hard for me to accept the idea that there is a meaning from God in sickness. The New Testament is full of stories about healing and it is very difficult to understand this. Sometimes, sickness seems like an absurdity. I wonder what theologians think about it.

A. The word "absurdity" which you have used is precisely it. People seek a meaning and they easily imagine that the only meaning sickness can have is that God is angry and punishing them. The day before yesterday I spoke on French television. I have seen that people too easily imagine that the meaning of illness is that it is a punishment from God. If you follow that to its logical conclusion, then I would be working against God by healing a person if God was punishing him by making him ill. I did say that God is always for healing and we struggle with Him for healing. Those who are best healed are those who can find a meaning in their illness. When illness has no meaning, it just adds to the suffering.

Q. Do you think that the structure of medical studies should be changed or is it only a matter for individual change?

A. I do not think the personal approach can be taught. I have been offered university chairs many times, in the U.S. or in Europe. I have always refused, saying that the personal relationship is something that is communicated from one person to another. It isn't something that is taught, or, if it is, I'm not the person to teach it. We are beginning to teach psychology in medical schools, and it's high time. But you can't teach medicine of the whole person. On the other hand, a medical school professor may have a feeling for humanity. I had one who had a profound sense of being human and he could communicate this feeling. But it wasn't teaching, it was communicating.

Q. Do you think a Christian working in a secular hospital can communicate this attitude without speaking about God?

A. I don't know. That's an individual question. Each person knows what God wants him to do; it's not for me to say. Basically, we have to ask God to tell us when to speak and when we should be silent. We often speak when we shouldn't or else we say nothing when we ought to speak. The worst thing is to feel obliged to speak.

Q. What do you see both as the responsibility and potential contribution of the congregation in this kind of personalized approach, not only to the wholeness of people but to the community of God and to the wider community?

A. I can't make generalizations because it depends so much on the individual congregation. I have been a member of several parishes, and I realize that the one in which I felt most comfortable was the one where there were very close personal ties among the leaders. These were not people who were simply elected to be in a certain position, but who really had personal ties. These relationships among the members, with the pastor, are very important for the life of the church. But, unfortunately, in the churches we often lag behind. I've treated enough church people to realize how much aggressivity and bad feelings they repress, to know that this is where it is perhaps most difficult because we have to hide behind a smile. Some people have told me they have broken into tears after leaving a church meeting because all the conflicts had been hushed up to give an impression that everybody was at peace with each other. Natural aggressivity could not be expressed, so it was repressed and took the shape of anxiety. I know that I myself am too afraid of conflicts. I always try to fix things up and that makes it even worse. I know too that Jesus knew moments of very healthy anger, holy anger perhaps. My son told me recently that he could never really confront me because I never got angry. I had been very proud of not getting angry and now I realize that it was unfortunate.

THE STUDY PROGRAMME OF THE CHRISTIAN MEDICAL COMMISSION ON THE CHRISTIAN UNDERSTANDING OF HEALTH, HEALING AND WHOLENESS

The following statement formulates the new directions our study is taking. We want to find out what local churches are thinking about health care and healing. We hope to learn about the different ways they are carrying out their healing, caring role. New attitudes towards health and wholeness are emerging in many parts of the world. Bringing them together is a purpose of our study. We will welcome any comments or contributions our readers have to make.

THE QUESTIONS

- What does "health" mean? "Wholeness"?
- In what ways can a congregation promote wholeness among its members and within its community? What does a "healing ministry" mean?
- Why, as Christians, should we be involved in healing?

The Christian Medical Commission is seeking answers to these questions. Our quest dates back to the 1960s. This study is part of our mandate from the Central Committee of the World Council of Churches. To start this new phase of enquiry, we have begun to build up a network of resource people in different countries of the world. From them we are gaining information about how local communities care for and support their sick and suffering members, about Christian perspectives and human values, about healing practices and attitudes within traditional societies in developing countries and about new thinking on the churches' involvement in healing, both of a theological and practical nature.

"HEALTH" AND "WHOLENESS": THEIR IMPLICATIONS FOR OUR HEALING MINISTRY

Responses received so far have a common denominator: it is the word *wholeness.* There is a realization that to experience healing is to know wholeness; there is a growing identification of "health" and "wholeness". This concept of wholeness has implications for everything we do as part of the healing ministry.

– Many patients and their families are looking for assurances that somebody cares about them and shows it by taking the time to listen. They need this as much as sophisticated equipment and efficient medical personnel. This asks of all those working in health to adopt an open and *communicating* approach to those who are sick and in need, an approach which reflects respect for them as whole human beings. Any illness, no matter how simple, generates other psychological, emotional and spiritual needs. In addition, it creates other needs in the family and social context of the ill person.

– This means a different approach to healing: seeing the sick person not just as an ailing body or a troubled mind or a hurt spirit, but as a *whole person.* This implies that skills other than the purely technical and medical are required to address the needs of the whole person. Wholistic clinics, often church-based and -funded, are one expression of this approach. These are clinics which make available to *every* patient the skills of pastoral counsellors, psychologists, social workers and nurses. Recently, Dr Paul Tournier, the well-known Genevese physician and author, spoke about his forty years' practice of "medicine of the whole person". He believes that a healing relationship requires a certain intimacy between people, a willingness to be subjective, personal, giving. It is important to recognize that *disturbed relationships* are very much a part of what brings on illness: physical, psychological and spiritual.

– The healing power of prayer has been proclaimed for centuries. In recent years, there has been a marked growth of prayer groups within many

churches. Members of such groups believe that prayer, offered in faith, can bring about a sense of wholeness in the face of illness and disability and also help people face death with equanimity and peace. The testimony of many who have experienced complete healing and achieved wholeness, are cited as further manifestations of the power of prayer.

- Wholeness also has to do with our relationships to the societies we live in, torn apart as they often are by injustices which deprive certain groups of their basic human rights. Primary health care, which the CMC has been promoting since its inception ten years ago, is one way of remedying unjust distribution of health care. This applies not only to urban/rural inequities and undue stress on curative and institutional services. It also emphasizes people's increased responsibility for their own health and the total involvement of communities, in their own health care. Wholeness also has to do with our relationship to that interdependent complex of air and water, earth and natural resources which is our environment.

- The concept of wholeness comes naturally to traditional healers. In societies where people still turn to them for most of their health needs (curative and preventive), harmony with one another and with nature is considered essential to good health. Within these societies where government and church hospitals still are able to meet only a part of the need for health services, traditional medicine co-exists with modern Western medicine. Yet as Zaïre theologian, Ma Mpolo Masamba, reminds us, Western medicine treats people as things whereas traditional African medicine treats them as whole persons. More than this, traditional midwives, acupuncturists and herbal practitioners have for centuries applied their skills effectively within their own communities. How can we bring together the best of both these types of medicine and shed our prejudices?

- In the past, manifestation of Christian concern for orphans, the aged, the handicapped and terminally ill has focused mainly on the provision of institutional care. Christians have often expressed their concern for these people's welfare simply by generous contributions of money. But what if institutions, by their impersonality, are not always the best answer? What are the alternatives? How can we best care for and be supportive of our family and neighbours when they are disabled in body or mind or spirit? Are we sensitive enough to recognize wholeness when we see it in someone who is elderly, physically handicapped or terminally ill? Can we recognize handicaps of mind and spirit in those who are ordinarily not considered disabled at all? Are not all those who suffer even temporary illnesses of body or mind in need of rehabilitation and restoration to wholeness?

WHAT PEOPLE ARE DOING

We believe that Christians all over the world are asking themselves these questions, just as we are in the CMC. The reason for our study programme is to try and find out some of the answers which grow from situations which are as widely diversified as our constituency.

These answers may be of a practical nature: to start a day-care centre for the children of working parents or dig a well to provide safe water. They may be an articulation of theology-in-action by those involved in health programmes. They may be Biblical reflections to assist in more clearly describing a "ministry of healing". All these can motivate us to find new and imaginative ways to serve our brothers and sisters, and to sustain us when the ways are difficult.

The CMC study is one part of the whole programme of the World Council of Churches. In cooperating with its theological extension and congregational renewal programmes, for instance, we want to find out what the churches can do to develop a broader understanding of support and healing.

It is creative material for the curricula of seminaries and lay training centres and constitutes strong stuff for discussion within congregations and among the theologically trained and the medically trained.

Through future issues of CONTACT, we plan to tell you about what we are learning as our study continues. In the August 1978 issue (see Chapter XIII), an article describes how churches can help in the rehabilitation of their physically and mentally handicapped members. A future issue will tell about the wholistic health care movement in the United States, and another will deal with traditional medicine.

If you would like to make a contribution to this study by telling us about what your church or other groups in your area are doing, or by sharing with us your thoughts on some of these questions, we would be pleased to hear from you.